Medical Necessity Certification

Complete this form for non-emergency scheduled and non-emergency unscheduled ambulance transport(s). This applies to repetitive transport and/or one-time transports.

Patient Name	Health Insurance Claim # (HIC)
Transport Date	
Transport From	Transport To

In order for ambulance service to be covered, the patient must be medically necessary and reasonable. Medical necessity is established when the patient's condition is such that transportation by any other means is contraindicated. For the ambulance claim to be evaluated under Medical coverage criteria, please complete the question below and attach additional sheets as necessary to include detailed information.

Please indicate whether the patient meets the following needs. *Details for these needs MUST be included. You MUST use the attached additional sheets and provide complete details.*

Check all that apply:

- ☐ Abnormal vital signs
- ☐ Advance decubitus ulcer
- ☐ Amputation
- ☐ Cancer – unspecified
- ☐ Cardiac symptom other than chest pain palpitations/dysrhythmia
- ☐ Comatose and requires trained monitoring
- ☐ Confined to bed
- ☐ Contractures of lower extremities
- ☐ Late effects of cerebrovascular disease:
  - ☐ Cognitive deficits
  - ☐ Hemiplegia dominant side
  - ☐ Hemiplegia nondominant side
  - ☐ Monoplegia of low limb dominant
  - ☐ Monoplegia of low limb nondominant side paralysis
- ☐ Medical device failure (ventilator, internal pacemaker, etc.)

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- ☐ Pain – needs special handling to be moved
- ☐ Pain exacerbated by movement
- ☐ Psychiatric (suicidal, violent, disoriented)
- ☐ Requires airway monitoring & suction
- ☐ Requires cardiac monitoring
- ☐ Requires continuous 02 & monitoring
- ☐ Requires continuous iv therapy
- ☐ Requires isolation precaution (VRE, MRSA, etc.)
- ☐ Requires restraints or sedation
- ☐ Requires wound precaution
- ☐ Remain immobile because of fracture not yet set
- ☐ Risk of falling off wheelchair while in motion
- ☐ Risk of falling off stretcher while in motion
- ☐ Sign of decreased level of consciousness
- ☐ Severe hemorrhaging
- ☐ Seizure-prone
- ☐ Sustained an acute stroke or myocardial infarction
- ☐ Temporary, recurring spells or reduced consciousness
- ☐ Total hip replacement requires hip precaution and cannot sit safely
- ☐ Transport required by state law or court order
- ☐ Ventilator dependant

☐ Other (please specify): ____

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I certify that the information contained herein is to the best of my knowledge, complete and accurate and supported in the medical record of the patient. The information being utilized on this form is being gathered to assist in seeking reimbursement from third party payers such as Medicare program. I understand that any intentional misrepresentation or falsification of essential information that leads to inappropriate payment may be subject to investigations under applicable federal and/or state law.

Your Name	Phone
Address	
Signature	Date

Medical Necessity Certification is good for 60 days from date of signature.

CARE FIRST EMS
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Detailed Information – *Must be completed and signed*

Patient's Name	
Doctor's Name	Doctor's Phone Number
Doctor's Signature	Date

Please elaborate on the diagnosis(s) listed on page 1 that make transport by ambulance medically needed (attach additional sheets if necessary):

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