



NON-REPETITIVE MEDICAL NECESSITY CERTIFICATION STATEMENT

Please Fax Completed Form to (989) 752-6803
To Schedule a Transport or for Assistance Please Call
(989) 907-2020 or (866) 781-3218

SECTION I – GENERAL INFORMATION

- 1) Patient's Name: _____ Date of Birth: _____
- 2) Transport From: _____ Transport To: _____
- 3) Transport Date: _____
- 4) Attending Physician: _____
- 5) *Is the Patient's stay covered under Part A (PPS/DRG)* Yes No

SECTION II - MEDICAL NECESSITY

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patient's condition: _____

2) **Bed Confined?** YES or NO (Circle One) **Bed Confined Definition - must meet all criteria:** *Inability to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair, per CMS rules.*

3) **Please Check All Required That Apply:**

- | | | |
|--|---|--|
| <input type="checkbox"/> Airway Compromise-Suction | <input type="checkbox"/> Cardiac Monitoring | <input type="checkbox"/> Comatose |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Contractures | <input type="checkbox"/> Danger to self/others |
| <input type="checkbox"/> Isolation Precautions | <input type="checkbox"/> IV Maintenance | <input type="checkbox"/> Moderate/severe pain on movement |
| <input type="checkbox"/> Paralysis (hemi, semi, quad) | <input type="checkbox"/> Non-healed fractures | <input type="checkbox"/> Oxygen monitored by trained staff |
| <input type="checkbox"/> Should not stand/pivot/ambulate | <input type="checkbox"/> Restraints | <input type="checkbox"/> Oxygen self-monitored |
| <input type="checkbox"/> Morbid Obesity | <input type="checkbox"/> Vent Dependent | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Unable to sit in a wheelchair due to decubitus ulcers or other wounds | <input type="checkbox"/> Monitored by trained staff | for _____. |
| <input type="checkbox"/> Unable to tolerate a seated position during transport | | |
| <input type="checkbox"/> Other (specify) _____ | | |

4) What services are required at receiving facility that **CAN NOT** be provided at the sending facility? _____

5) Closest facility? YES or NO (Circle One) If NO, why is transport to more distant facility required? _____

6) Can this patient safely be transported by car or wheelchair van (i.e., may safely sit during transport, without an attendant or monitoring?) Yes or No (Circle One)

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows: _____

Print Name: _____ Credential: _____

Sign Name: _____ Date Signed: _____

Physician NPI Number: _____ (as applicable)

Who Can Sign a Non-Repetitive Medical Necessity Certification Statement:

Physician, Physician Assistant, RN, Clinical Nurse Specialist, LPN, Nurse Practitioner, Social Worker, Case Manager or Discharge Planner
Jan2020