SECTION I – GENERAL INFORMATION

Patient Name: _____ Date of Service: _____ Medicare #: _____

Origin: _____ Destination: _____

Is the patient's stay covered under Medicate Part A (PPS/DRG?) ☐ Yes ☐ No

Closest appropriate facility? ☐ Yes ☐ No If no, why is transport to more distant facility required? _____

_____

If hospital to hospital transfer, describe services needed at 2nd facility not available at 1st facility: _____
If hospice patient, is the transport related to patient's terminal illness? ☐ Yes ☐ No

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

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) Is the patient "bed confined" as described below? ☐ Yes ☐ No
To be "bed confined" the patient must satisfy all of the following conditions: (1) The patient is unable to get up from bed without assistance. AND 2) unable to ambulate: AND (3) unable to sit in a chair or wheelchair.

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring? ☐ Yes ☐ No

4) In addition to completing the questions 1–3, please check any of the following conditions that apply*:
*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records.

☐ IV meds/fluids required ☐ Requires oxygen–unable to self administer ☐ Cardiac monitoring required en route
☐ Contractures ☐ Orthopedic device requires special handling during transport ☐ Medical attendant required
☐ Moderate/severe pain on movement ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose
☐ Danger to self/others ☐ Patient is combative ☐ Unable to tolerate seated position for time needed to transport
☐ DVT requires elevation of lower extremity ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Hemodynamic monitoring required en route ☐ Special handling/isolation/infection control precautions required
☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds ☐ Need or possible need for restraints
☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represents that the patient requires transport by ambulance and that other means of transport are contraindicated. I understand that 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 patient's attending physician, or an employee of the patient's attending physician, or the hospital or facility where the patient is being treated and from which the patient is being transported; that I have personal knowledge of the patient'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 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:

_____

_____ _____ _____
Signature of Physician or Healthcare Professional NPI # Date Signed

_____
LEGIBLY PRINT NAME AND CREDENTIALS OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

Original: Chart **Yellow: EMS Provider**

McLaren
NORTHERN MICHIGAN

Medical Necessity Statement for Ambulance Service
MNM 601.981

MHCC-714-MNM (10.23)