A-TEC Ambulance, Inc.
Certificate of Medical Necessity

Fax: 847-697-7723

SECTION I – GENERAL INFORMATION

Patient's Name:_____ Date of Birth:_____Transport Date:_____

Medicare #: ____ ____ ____ - ____ ____ - ____ ____ ____ ____ ____ Medicaid #:___ ___ ___ ___ ___ ___ ___ ___ ___ ☐ Illinicare ☐ Atena Better Health

Origin: _____Destination:_____
Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

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

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility:_____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe:_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Please acknowledge by checking the box below the patient's medical condition AT TIME OF TRANSPORT that requires:

☐ **Non-Emergency Ambulance** – Transportation of a patient whose medical condition requires transfer by stretcher and medical monitoring. The patient's condition may also require medical equipment and/or the administration of medications and/or oxygen, ect. during transport.

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

2) Is this patient "bed confined" as defined below?☐ Yes ☐ No
To be "bed confined" the patient must satisfy **all three** of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair

3) ***In addition*** to completing questions 1-3 above, 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****

☐ Contractures (Location: _____) ☐ Non-healed fractures (Location: _____) ☐ Patient is confused
☐ Patient is comatose ☐ Moderate/severe pain on movement ☐ Danger to self/other ☐ IV meds/fluids required ☐ Patient is combative
☐ Need or possible need for restraints ☐ DVT requires elevation of a lower extremity ☐ Medical attendant required
☐ Requires oxygen – unable to self administer ☐ Special handling/isolation/infection control precautions required
☐ Unable to tolerate seated position for time needed to transport ☐ Hemodynamic monitoring required enroute
☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wound(s) (Stage(s): _____ Location(s): _____)
☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ 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 represent that the patient requires transport by ambulance and that other forms 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, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **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 | Date Signed
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____
Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

Medicare: (only those listed below may complete form)
☐ Physician Assistant ☐ Clinical Nurse Specialist
☐ Nurse Practitioner ☐ Discharge Planner
☐ Registered Nurse

Medicaid: (any of the previous plus those listed below)
☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Case Worker
☐ Nurse Practitioner ☐ Discharge Planner
☐ Registered Nurse ☐ Licensed Practical Nurse