NORTH MEMORIAL HEALTH	**CONTACT DISPATCH** **Fax:(763)581-9888** Phone:(763) 520-2897 (800) 667-8421	**FOR AIRCARE CALL** **1-800-247-0229**

"MEDICAL NECESSITY CERTIFICATION STATEMENT"

FOR AMBULANCE TRANSPORTATION

Section 1 – Beneficiary Information

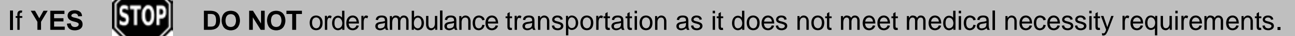
Patient Name:________________________________ **Diagnosis:**________________________________

Date of transport:_____________________________ Medicare/Medicaid #:_________________________

Pickup:_____________________________________ Destination:______________________________

Section 2 – Medical Necessity Information – (NON-EMERGENCY TRANSPORT)

☐ Yes ☐ No 1. Can the patient be safely transported by car, taxi, bus or a wheelchair van, seated for the duration of the transport **and without** a medical attendant?



If **YES** STOP **DO NOT** order ambulance transportation as it does not meet medical necessity requirements.

2. If NO, describe in detail the medical reason(s) why the patient requires monitoring, an attendant and/or transport by ambulance. ________________________________

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Section 3 – HOSPITAL TO HOSPITAL TRANSFERS ONLY

☐Yes ☐No Is the patient being transferred to a higher level of care?

MUST describe in detail Medical Facilities or Procedure(s) required/available at destination facility not available at originating Facility____

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☐Yes ☐No The patient was discharged from the originating facility.

☐Yes ☐No The patient is being transported to the closest appropriate facility.

If NO describe why the patient must be transported to the further facility: _________________

____

If NO, the patient/family has been notified they will be responsible for the additional mileage charges beyond the closest appropriate facility. ☐Yes ☐No

☐Yes ☐No The patient is critically ill or injured, unstable, or in need of immediate intervention.

☐Yes ☐No **AIR CARE ONLY**

Due to the medical condition of the patient and/or the need for rapid transport, the patient requires transport by AIR AMBULANCE.

Section 4 – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

____ Physician NPI:______________________(if known)

LEGIBLY PRINT the FULL name of the Physician or Health Professional ordering transport that **signed** this form.

____ Date: ________________________________

SIGNATURE of Physician or Healthcare Professional ordering transportation

Check appropriate box for the professional that signed this form:

☐ Physician (Circle: MD DO DPM) ☐ PA ☐ NP ☐ Clinical Nurse Specialist

☐ RN ☐ LPN ☐ Social Worker ☐ Case Manager ☐ Discharge Planner

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 services claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature above 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 incapable of signing the claim form is:**

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