MILWAUKEE (414) 933-7600
MADISON (608) 255-4140
MEDIX (262) 539-2680

MEDICAL NECESSITY CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORT

PLEASE DOCUMENT ALL THAT APPLY IN DETAIL

Patient Name:____ Date of Transport:__________________

From:_______________________________________ To:____

☐ **ROUND TRIP TRANSPORT** (PCS applies to both trips)

In my professional opinion, this patient requires transport by ambulance and should not be transported by other means due to the reason(s) listed below:

☐ REQUIRES **OXYGEN** DURING TRANSPORT
Does patient have his/her own portable oxygen? ☐ Yes ☐ No
Is patient able to administer his/her own oxygen? ☐ Yes ☐ No

If No, WHY:____

☐ REQUIRES **RESTRAINTS**
☐ Physical – Type____________ ☐ Chemical – Type____________
Reason:
☐ To maintain upright position ☐ To prevent from falling
☐ Prevent from injury to self or others ☐ Flight risk

☐ REQUIRES **ISOLATION PRECAUTIONS**

Why:____

☐ **IMMOBILIZED** DUE TO RECENT OR POSSIBLE FRACTURE

☐ Hip ☐ Leg ☐ Neck ☐ Other:_________________________

☐ **CONTRACTED** AND **CANNOT** SIT UP IN A WHEELCHAIR

☐ Upper Extremities ☐ Lower Extremities ☐ Fetal

☐ HAS **DECUBITUS ULCERS**: Size:_______ Stage:______

Location: ☐ Buttocks ☐ Coccyx ☐ Hip ☐ Other:______________

☐ **NOT WHEELCHAIR ABLE**
Risk of falling of wheelchair or stretcher while in motion.
Reason(s): ☐ Poor Trunk Control ☐Postural Instability
☐ Spastic/Jerking Movement ☐ Fetal position

☐ Other:____

☐ SUFFERS FROM **PARALYSIS**: ☐ Para ☐ Quad ☐ Hemi

☐ PATIENT IS **BED-CONFINED** i.e.: Patient is unable to get up from bed without assistance **and** unable to ambulate **and** unable to sit in a chair or wheelchair. **(MUST meet all three criteria in order to meet the definition of "bed-confined".)**

☐ **AMPUTATION** AND **CANNOT** SIT UP IN WHEELCHAIR
☐ Right ☐ Left ☐ Bilateral ☐ Above knee ☐ Below knee

☐ REQUIRES **TRAINED MONITORING** FOR:
☐ Airway control/positioning or suctioning
☐ Continuous IV therapy
☐ Ventilator dependent / advanced airway monitoring
☐ Cardiac monitoring
☐ Is medicated and requires monitoring
☐ Danger to self or others
☐ Acute Condition: EXPLAIN:_________________________________

☐ **MORBID OBESITY** Patient Weight:______________
Additional personnel required? ☐ Yes ☐ No How many:__________

☐ **SEVERE PAIN** Pain Scale (1-10):___________
Pain must be aggravated by transfers or moving vehicle such that trained expertise of EMT is required.
Detailed Explanation:_______________________________________

☐ PATIENT HAS **ALTERED MENTAL STATUS**
Is this condition: ☐ New Onset ☐ Normal Status ☐ Status Change
Does the patient exhibit any following behaviors?
☐ Hostile ☐ Violent ☐ Agitated ☐ Non-Compliant

☐ PATIENT EXHIBITS A **DECREASED LEVEL OF CONSCIOUSNESS**
☐ Unconscious ☐ Semi-conscious, stuporous ☐ Syncope
☐ Seizure prone ☐ Unresponsive ☐ Incoherent
☐Hallucinating ☐ Intermittent consciousness ☐ Lethargic
☐Head injury with altered mental status

FACILITY TO FACILITY TRANSPORTS REASON FOR TRANSFER – **CHOOSE ONE:**
☐ Services are not available at originating facility. What services: ________________________________
☐ Insurance Request ☐ Physician request/Convenience ☐ Patient/Family Request ☐ No beds available at originating facility
Level of Service requested by physician: ☐ BLS ☐ ALS ☐ Critical Care/SCT

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services. Health Care Financing Administration (HCFA) to support the determination of medical necessity for ambulance services.

Signature Of Healthcare Professional:_____________________________ Date:______________________

Title: ☐ M.D./D.O. ☐ RN/LPN ☐ Discharge Planner ☐ PA
☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐Case Manager

Printed Name:_____________________________