CLEAR FORM E-MAIL PRINT

LIVINGSTON COUNTY EMS
NON-EMERGENCY TRANSPORT REQUEST

Patient Name: _____ D.O.B. _____

Mailing address _____ Phone _____

Health Insurance: _____ Policy # _____

Group # _____ Policy Holder: _____

Health Insurance: _____ Policy # _____

Group # _____ Policy Holder: _____

Date of Requested Transport: _____ Requested Pick up Time: _____
☐ One Way transport or ☐ Wait and return Appointment Time: _____
If for a procedure list here: _____

Special needs: ☐ Vent dependent ☐ Oxygen ☐Cardiac Monitor ☐Obesity #_____
☐ Dialysis or other recurring procedure ☐ Other: _____

If Altered mental status or nonverbal do they have a representative accompanying them?
☐ YES ☐ NO Name: _____

Pick Up Location Facility Name: _____ Rm# _____
Pick Up Facility Address: _____
Pick Up Facility Contact: _____Phone: _____

Drop Off Facility Name: _____ Rm# _____
Drop Off Facility Address: _____
Drop Off Facility Contact: _____Phone: _____

Reason for Ambulance transport request: _____
Is this patient Bed Confined by CMS definition? ☐ YES ☐ NO

The HCFA definition of Bed-Confinement is: The inability to get up from bed without assistance; ambulate; and sit in a chair, including a wheelchair. (ALL MUST BE MET)

Run #

Billing Questions: (517) 546-6220
CMS Form Fax: (517) 546-6788

Patient Sticker Here

AMBULANCE TRANSFER FORM (CMS)

Certification of Medical Necessity Statement

Diagnosis _____ **Current Chief Complaint** _____
Patient Name: _____ **Transport Date** _____ **Date of Birth** _____
Transport From: _____ **Rm#** _____ **Attending Physician** _____
Transport To: _____ **Rm#** _____ **Receiving Physician** _____

TRANSFER TO ANOTHER FACILITY, CHECK ALL THAT APPLY

☐ Requires specialty facility or special services not provided at our facility, please explain _____
☐ Patient family/convenience request for transfer
☐ No appropriate bed available at our facility, please explain _____

OPTION 1: In my professional medical opinion**, this patient does not require transport by ambulance and can safely be transported by other means.** The patient's condition is such that transportation by ambulance is not required because the means listed below is safe and acceptable:

☐ Patient can safely support him / herself while seated in wheelchair and does not require monitoring by trained personnel.
☐ Patient is able to tolerate transportation by automobile or wheelchair van.

If Option one is selected and ABN will be required prior to the ambulance transport! Other transportation options should be considered.

OPTION **2:** **In my professional medical opinion**, this patient requires transport by ambulance and should not be transported by other means. **This patient's condition is such that transportation and monitoring by medically trained personnel** *is required*.

The HCFA definition of Bed-Confinement is: The inability to get up from bed without assistance; ambulate; and sit in a chair, including a wheelchair. (ALL MUST BE MET)

♦ Is your patient bed-confined as described by Medicare (HCFA) Regulation? ☐ **Yes** ☐ **No**

If the patient does not meet bed-confined criteria as defined above, can this patient be safely transported by wheelchair van? ☐ **Yes** ☐ **No – If no please check the appropriate medical conditions listed below which would necessitate transport by ambulance** and make all other means of transportation contraindicated based on patient safety and health.

CHECK ALL THAT APPLY TO YOUR PATIENT

☐ Exhibiting signs of decreased level of consciousness ☐ Patient is ventilator dependent
☐ Requires monitoring (check all that apply): ☐ Airway ☐ IV ☐ Cardiac EKG ☐ Seizure prone ☐ Medication _____
☐ Could only be moved by stretcher because of: _____
☐ Requires oxygen 2 L/min during transport because of: _____
☐ Unable to sit due to decubitus ulcers of the: _____
☐ Requires (check all that apply): ☐ psychiatric hold ☐ restraints ☐ flight risk
☐ Unconscious or in shock
☐ Isolation precautions
☐ Unable to sit or hold self in place, even with seatbelts, due to paralysis or contractures of the _____

INTERFACILITY TRANSFER ORDERS

Orders for Transfer:
Oxygen: ☐ _____ l/min ☐ mask ☐ NC ☐ SaO2 ☐ EKG Monitoring
IV #1 Solution/Medication _____ Rate _____ Site _____
#2 Solution/Medication _____ Rate _____ Site _____
#3 Solution/Medication _____ Rate _____ Site _____
Medication/Treatment orders: _____
Other Orders: _____

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required. I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge. I understand that this information will be used by the Centers for Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services.

Please check your credentials below and print and sign your name:

☐ Physician ☐ RN ☐ NP ☐ PA ☐ LPN ☐ CNS ☐ Discharge Planner ☐ Case Manager

_____ NPI# _____ _____ _____
Printed Name Signature Date

Medical Necessity Certification
For Non-Emergency Scheduled and Unscheduled Medical Transportation Services

Provided by Livingston County Emergency Medical Services

MEDICAL NECESSITY CERTIFICATION CRITERIA

BACKGROUND

As of February 24, 1999 HCFA requires a physician statement of medical necessity for interfacility transportation by ambulance.

DEFINITIONS and REQUIREMENTS

Emergency:

An Emergency is defined as: The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- ✓ Placing the patient's health in serious jeopardy
- ✓ Serious impairment to bodily functions; or
- ✓ Serious dysfunction of any bodily organ or part.

Non-Emergency:

Patient's conditions not meeting the above definition for emergency are considered non-emergency.
Section 410.40 (d)(1) states that a non-emergency will only be considered medically necessary if:

- ✓ The beneficiary is unable to get up from bed without assistance
- ✓ The beneficiary is unable to ambulate, **and**
- ✓ The beneficiary is unable to sit in a chair, or a wheelchair.

OR

- ✓ If there is a Physician's written order certifying that the beneficiary must be transported in an ambulance because other means of transportation are contraindicated

Scheduled:

For scheduled non-emergencies, Section 410.40 (d)(2) requires the ambulance supplier to obtain a written order from the attending physician, before transport, certifying the medical necessity requirements (listed above) are met. The physician's order must be dated no earlier than 60 days prior to transport, except as noted below.

- ✓ For repetitive patients, (e.g. dialysis, radiation therapy, chemotherapy, etc.) the physician certificate will be good for 60 days from the date it is signed.

Unscheduled Non-Emergency:

- ✓ For a resident of a facility under the care of a physician, the certification can be obtained up to 48 hours after the transport.
- ✓ No certification is required for a patient living at home or in a facility, but not under the direct care of a physician.

Exception

The regulation specifically states "We recognize that it is standard and accepted medical practice both in hospitals and nursing homes to take steps to ensure that beneficiaries are up and out of bed as often as their condition permits. Such beneficiaries are not bed-confined. It is incumbent upon health care professionals responsible for the care of individual beneficiaries to determine what is safe for those beneficiaries. If it is determined that it is unsafe for a particular beneficiary to be unmonitored during transport, **then the documentation submitted for that particular transport should support the need for ambulance transportation**. That documentation will be considered by the processing of the claim." **(Emphasis added)**

YOUR SIGNATURE CERTIFIES THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF YOUR KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FROM THIRD PARTY PAYERS SUCH AS THE MEDICARE PROGRAM. YOU UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, MAY BE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND/OR STATE LAWS.