Medevac 24/7 Dispatch ☐ (877) 985-5022 ☐(907)310-9001 ☐(251) 348-7644 Fax 877-730-2418

# CERTIFICATE OF MEDICAL NECESSITY

## SECTION 1 – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ This CMN is Valid for ☐ Today or ☐ Date Range: _____ to: _____ (no more than 60 days)

Origin: _____ Destination: _____

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

Closest Appropriate Facility? ☐ YES ☐NO If NO, why is transport to a more distant facility required? _____

_____

If hospital to hospital transfer, what services at destination that are required: _____

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

## SECTION 2 – 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 in the following? 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.

☐ YES. ☐ NO

3) Can the patient be safely transported by car or wheelchair van? (i.e. seated during transport without a medical attendant)

☐ YES. ☐ NO

4) In addition to items 1-3 above, please check any of the following conditions that apply as supporting documentation. The supporting documentation must be maintained in the patient's medical records.

☐ Cardiac Monitoring Required ☐ Danger to Self/Others ☐ Patient is confused ☐Contractures

☐ Requires Continuous IV Therapy ☐ Moderate/Severe Pain with Movement ☐ Patient is comatose

☐ Is Ventilator Dependent ☐ Need/Potential Need for Restraints ☐ Medical Attendant Required

☐ Special Isolation Precautions (i.e. Neutropenic, Contact, Airborne and/or Droplet) ☐ Non-Healed Fractures

☐ Requires Oxygen & unable to self-administer ☐ Orthopedic Device (Backboard, splint, pins, etc.) requiring special handling

☐ Hemodynamic Monitoring Required ☐ Unable to sit in chair/wheelchair due to decubitus ulcers

☐ DVT lower extremity that req. Special Positioning ☐ Morbid Obesity req. additional personnel to safely handle patient

☐ Other (specify): _____

5) If air transport is covered under a portion of this medical necessity, please specify why air transport is necessary vs. all other modes:

☐ Long Distance: pt.'s condition requires rapid transport over long distance ☐ Pick up point is not accessible by ground transportation

☐ Unstable Patient with need to minimize out of hospital time ☐ Traffic patterns preclude ground transportation at this time

☐ Other (specify): _____

## SECTION 3 – 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

_____ _____

Printed Name of Physician or Healthcare Professional Credentials (MD, DO, PA, NP, RN, CNS)

*Form must be signed by patient's attending physician for repetitive transports (If 60 day option is checked above). For unscheduled transports, this form may be signed by a Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse or Discharge Planner if their attending physician is not immediately available.*