MEDA CARE AMBULANCE SERVICE

MILWAUKEE
414-344-4444
Nationwide Toll-Free: 866-525-8888

Certificate of Medical Necessity (CMN) for Non-Emergent Ambulance Transport

A CMN is required for non-emergency ambulance transports to establish medical necessity. REV D-2017

Transport Date: _____ Origin: _____ Destination: _____

Patient's Name (print): _____ Physician: _____

Certificate of Medical Necessity for Repetitive Ambulance Transport: Complete on reverse side.

In my professional opinion, this patient requires transport by ambulance and should not be transported by other means for one or more of the following reasons:

☐ **BED-CONFINED** (Patient unable to get up from bed without assistance, unable to ambulate, and unable to sit in chair or wheelchair.)

Reason: _____

☐ This patient cannot be safely transported while strapped in a wheelchair that is bolted to the floor and unattended in the back of a moving wheelchair van.

Reason: _____

☐ **IMMOBILIZED** due to recent fracture or possible fracture:

☐ Hip ☐ Leg ☐ Neck ☐ Other: _____

☐ **CONTRACTED** and **CANNOT SIT** up in a wheelchair:

☐ Upper Extremities ☐ Lower Extremities ☐ Fetal

☐ Suffers from **PARALYSIS**: ☐ Para ☐ Quad ☐ Hemi

☐ 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: _____

Reason: _____

☐ Requires **RESTRAINTS**

☐ Physical—Type: _____ ☐ Chemical—Type: _____

Reason: _____

☐ Requires **ISOLATION PRECAUTIONS**

Reason: _____

☐ **DECUBITUS ULCERS**: Size _____ Stage _____

Location: ☐ Buttocks ☐ Coccyx ☐ Hip ☐ Other: _____

☐ Requires **OXYGEN** Enroute.

Is patient able to administer his or her own oxygen? ◯ Yes ◯ No

☐ **ALTERED MENTAL STATUS**

Condition: ☐ New Onset ☐ Status Change

Patient exhibits: ☐ Hostile ☐ Agitated ☐ Violent ☐ Non-compliant

Is the altered mental status the result of sedation? ◯ Yes ◯ No

Type: _____

☐ Exhibits a **DECREASED LEVEL OF CONSCIOUSNESS**

☐ Unconscious ☐ Stuporous (Semi-conscious)

☐ Unresponsive ☐ Intermittent Consciousness

☐ Incoherent ☐ Hallucinating

☐ Lethargic ☐ Head injury with altered mental status

Hospital-to-Hospital Ambulance Transport CMN

Reason for Transfer: ☐ Service(s) not available at originating facility ☐ Patient / Family Request for Transfer ☐ Insurance Transfer

What service(s)? _____ Additional information: _____

Is this the closest facility capable of performing special service(s)? ◯ Yes ◯ No

If no, which facility is closest? _____

☐ Physician Requests Level of Transport: ☐ BLS ☐ ALS ☐ CRITICAL CARE ☐ RN

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 certify that this patient requires ambulance transport based on the above information. I understand that this information will be used by the Department of Health Services and the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and 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 | Print Name | Date: _____

NPI No.: _____

If signed by a Healthcare Professional other than the attending physician, please indicate title of signer below.

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner

PRINT TO SIGN FORM

Repetitive Ambulance Transport CMN

CERTIFICATE OF MEDICAL NECESSITY
FOR REPETITIVE AMBULANCE TRANSPORT

Patient's Name (Last, First)**:** _____

Origin: _____

Destination: _____

Only the Physician ordering the treatment requiring transport can complete a Certificate of Medical Necessity.

Repetitive Transport—Three or more trips in a 10-day period or at least once a week for three consecutive weeks. Examples of necessity for repetitive transport may be dialysis, radiation, wound care, etc.

Initial Transport Date: _____ Expiration Date (*Maximum 60 days from date signed*): _____

When a patient's condition is such that an ambulance is required to safely transport the patient, the medical necessity of transport must be certified by the physician. Describe the condition of the patient requiring an ambulance transport (Examples: history of stroke with residual paralysis, inability to sit safely in a chair for longer than 20 minutes, amputation of lower extremity, etc.).

BE VERY SPECIFIC:

Date that client was last seen by the Physician certifying the ambulance transport: _____

Physician's Name (print): _____ Telephone No.: _____

Physician's Signature: _____ NPI No.: _____ Date Certified: _____