Dynamic Ambulance, Inc.
Physician's Medical Necessity Certification

SECTION I – GENERAL INFORMATION

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

Initial Transport Date:_____ Repetitive Transport Expiration Date (Max 60 Days From Date Signed):_____

Origin:_____ Destination:_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR**, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered by the medical professional signing below for this form to be valid:

1) Is this patient "bed confined" as defined above? ☐ Yes ☐ No

2) Describe the Medical CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?)
☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Moderate/severe pain on movement

☐ Danger to self/others ☐ IV meds/fluids required ☐ Special handling/isolation required

☐ Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute

☐ Restraints (physical or chemical) anticipated or used during transport

☐ Patient is confused, combative, lethargic, or comatose

☐ Cardiac/hemodynamic monitoring required enroute

☐ DVT requires elevation of a lower extremity

☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport

☐ Unable to maintain erect sitting position in a chair for time needed to transport

☐ Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks

☐ Morbid obesity requires additional personnel/equipment to safely handle patient

SECTION III – 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 due to the reasons documented on this form. 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 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

_____ ☐ *Registered Nurse* ☐ *Discharge Planner* ☐ *Physician Assistance*

Printed Name of Healthcare Professional* ☐ *Nurse Practitioner* ☐ *Clinical Nurse Specialist*