FREESTATE AMBULANCE

The Industry Leader In Timely, Compassionate, and Reliable Transportation

Physician's Medical Necessity for Ambulance Transport

Transport Date: _____/_____/_____ Transport #:_____

Origin: _____ Unit/Floor: _____

Destination: _____

Patient's Name: _____ DOB: _____ Medicare or SSN: _____

Physician Name: _____ Phone: _____ Fax: _____

Complete by explaining reason(s) why patient requires non-emergency ambulance services.

PT is unable to sit or travel in a wheelchair due to:

_____

☐ Monitoring/treatment is required during transport

(Please check off and explain in detail any of the following that would support the ambulance transport)

- ☐ Is ventilator dependent (Explain below)
- ☐ IV Medications required en route (Explain below)
- ☐ ECG monitoring required en route (Explain below)
- ☐ Requires continuous oxygen (Explain below)
- ☐ requires airway monitoring or suctioning (Explain below)
- ☐ Has decubitous ulcers & requires wound precautions (Explain below)
- ☐ Isolation precautions due to:_____ _____
- ☐ Is seizure, decreased Consciousness, or comatose requiring trained monitoring (Explain below)
- ☐ Has or is suspected to have a psychiatric condition (Explain below)
- ☐ Orthopedic Device due to: _____
- ☐ Is Bed confined due to: _____
- ☐ If you believe there are other reasons please check the preceding box and specify them below:

_____

_____

_____

_____

* **Hospital to Hospital Transports ONLY**: What special services/treatments were needed and not available at sending facility?

_____

☐ Physician ☐ RN ☐ Discharge Planner ☐ NP ☐ PA ☐ CNS

_____

Printed Name **Signature** **Date**

Physician Certification Statement Pursuant to CFR[Section 410.40 (d) (2-3)] Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is contraindicated by the patient's condition. The Centers for Medicare and Medicaid services requires documentation of the medical necessity for such services.

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