

**SECTION I – GENERAL INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Transport Date: \_\_\_\_\_ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)  
Origin: \_\_\_\_\_ Destination: \_\_\_\_\_  
Is the pt's stay covered under Medicare Part A (PPS/DRG?)  YES  NO  
Closest appropriate facility?  YES  NO If no, why is transport to more distant facility required? \_\_\_\_\_  
If hosp-hosp transfer, describe services needed at 2<sup>nd</sup> facility not available at 1<sup>st</sup> facility: \_\_\_\_\_  
If hospice pt, is this transport related to pt's terminal illness?  YES  NO Describe: \_\_\_\_\_

**SECTION II – 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 this patient "bed confined" as defined below?  Yes  No  
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
- 3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?)  
 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  Patient is confused  Patient is comatose  Moderate/severe pain on movement  
 Danger to self/other  IV meds/fluids required  Patient is combative  Need or possible need for restraints  
 DVT requires elevation of a lower extremity  Medical attendant required  Requires oxygen – unable to self administer  
 Special handling/isolation/infection control precautions required  Unable to tolerate seated position for time needed to transport  
 Hemodynamic monitoring required enroute  Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds  
 Cardiac monitoring required enroute  Morbid obesity requires additional personnel/equipment to safely handle patient  
 Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport  
 Other (specify) \_\_\_\_\_

**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 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

(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

**Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)**

*\*Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Registered Nurse         | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Nurse Practitioner  | <input type="checkbox"/> Discharge Planner         | <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Case Manager  |