

CERTIFICATE OF MEDICAL NECESSITY For Medical Transportation Service

Transport Date: _____ / _____ / _____

Patient's Name: _____ Diagnosis / Complaint: _____

Transport From: _____ Transport To: _____

Procedure / Reason for Transport: _____

This Patient Requires Transport By Ambulance And Should Not Be Transported By Other Means

(facility staff must complete 1, 2, 3 and 4 below for all patients)

1. His/Her medical condition is such that ambulance transportation is medically required because he/she (check all that apply):

- is being transported as a result of an accident, injury or illness
- needs to be restrained (either physical, chemical or psychiatric reasons)
- needs other medical or mental health monitoring
- is unconscious or in shock
- is exhibiting signs of an decreased level of consciousness
- requires or may require oxygen during the trip
- must remain immobile because of diagnosis or suspected fracture
- needs monitoring and treatment for suspected stroke or MI
- is experiencing severe hemorrhage
- has decubitus ulcers & requires wound precautions
- needs airway monitoring or suctioning
- needs isolation precautions
- is seizure prone & requires monitoring by trained personnel

2. The Medicare definition of "bed confined" is that a person is unable to do all three of the following activities: get up from bed without assistance, walk, and sit in a chair or wheelchair. Is this patient "bed confined" according to Medicare's definition?

- Yes No (if no, please complete a Medicare NEMB)

3. Is this patient being transported to the closest facility able to treat the patient?

- Yes No (if no, please complete a Medicare NEMB and the questions below)

What is the closest facility: _____

Why isn't the patient going there? _____

4. Is an immediate response needed for this trip? Yes No

5. While patient is able to sit in a wheelchair, the patient cannot tolerate sitting in a wheelchair in a moving van without an attendant to care for them.

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.

Signature of Physician, RN, PA, CSW,
Case Manager or Discharge Planner

Printed Name & Title

Date
Signed

No Stretcher Ambulance Needed

This patient does not require transport by ambulance and can safely be transported by other means. Please complete the Medicare NEMB.

Signature of Physician, RN, PA, CSW,
Case Manager or Discharge Planner

Printed Name & Title

Date
Signed