MOBILE MEDICAL RESPONSE

NON-REPETITIVE MEDICAL NECESSITY CERTIFICATION STATEMENT

Please Fax Completed Form to (989) 752-6803
To Schedule a Transport or for Assistance Please Call
(989) 907-2020 or (866) 781-3218

SECTION I – GENERAL INFORMATION

1) Patient's Name:_____ Date of Birth: _____
2) Transport From Facility:_____Transport To Facility:_____
3) Transport Date: _____
4) Attending Physician:_____
5) ***Is the Patient's stay covered under Part A (PPS/DRG)*** **Yes No**

SECTION II - MEDICAL NECESSITY

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) ***Bed Confined***? **YES** or **NO** *(Circle One)*

Bed Confined Definition - **must meet all criteria**: *Inability to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair, per CMS rules.*

3) ***Please Check All Required That Apply***:

__ Airway Compromise-Suction
__ Confusion
__ Isolation Precautions
__ Paralysis (hemi, semi, quad)
__ Should not stand/pivot/ambulate
__ Morbid Obesity
__Cardiac Monitoring
__ Contractures
__ IV Maintenance
__ Non-healed fractures
__ Restraints
__ Vent Dependent
__ Comatose
__ Danger to self/others
__ Moderate/severe pain on movement
__ Oxygen monitored by trained staff
__ Oxygen self-monitored
__ Psychiatric care
__ Monitored by trained staff for_____.
__ Unable to sit in a wheelchair due to decubitus ulcers or other wounds
__ Unable to tolerate a seated position during transport
__ Other (specify) _____

4) What services are required at receiving facility that **CAN NOT** be provided at the sending facility?
_____

5) Closest facility? **YES** or **NO** (Circle One) If **NO**, why is transport to more distant facility required?
_____

6) Can this patient safely be transported by car or wheelchair van (i.e., may safely sit during transport, without an attendant or monitoring?) Yes or No (Circle One)

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

☐ **If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form 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:** _____

Print Name:_____**Credential:** _____

Sign Name:_____**Date Signed:**_____
Physician NPI Number:_____(as applicable)

***Who Can Sign a Non-Repetitive Medical Necessity Certification Statement*:**
Physician, Physician Assistant, RN, Clinical Nurse Specialist, LPN, Nurse Practitioner, Social Worker, Case Manager or Discharge Planner

Jan2020