1626 Atlantic University Circle Jacksonville, FL 32207 904.721.0008

Certificate of Medical Necessity

The physician responsible for determining medical necessity of non-emergency ambulance transport should complete this form. This form may also be completed and signed by an RN, PA, NP, CNS, or discharge planner who is employed by the hospital or facility where the patient is being treated, with knowledge of the patient's condition at the time of transport. For repeated transports, this form must be completed ONLY by the physician, and must be re-validated every 60 days. We are REQUIRED by Medicare law to present this form during audit for any nonemergency ambulance transport.

Patient Name _____ SS# _____

Medicare Part B benefits are payable for ambulance services only when the use of any other method of transport is medically contraindicated by the patient's condition. If the decision to use ambulance transport is based on the convenience of the patient, the patient's family, the patient's physician, or some other element of personal preference, Medicare coverage IS NOT available.

Please validate the patient's condition below:

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.

Can this patient safely be transported by car or wheelchair van? □ **Yes** □ **No**

Please check all that apply (in addition to answering questions above):

☐Contractures	☐Non-healed Fractures	☐Patient confused
☐Danger to self/others	☐IV Meds required	☐Patient comatose
☐Restraints required	☐Oxygen – unable to self admin	☐Patient combative
☐Infection precautions	☐Cardiac monitoring required	☐Morbid Obesity

☐Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc...) requiring special handling

☐Other (specify) _____

_____

Physician/Staff Signature _____ Date _____

Physician/Staff Printed Name _____

The completed form should be faxed to Liberty Ambulance Service at 904.724.0226 **BEFORE** calling for transport.