

MEDICAL NECESSITY CERTIFICATION STATEMENT RUN #

FOR AIR AND GROUND AMBULANCE TRANSPORT

BENEFICIARY INFORMATION

Place patient identification sticker here or record:	Date of Transport	
Patient Name: _____	Sending Facility	
DOB: _____	Receiving Facility	
Medical Record Number: _____	Diagnosis	

MEDICAL NECESSITY INFORMATION

NOTE: LACK OF ALTERNATIVE TRANSPORTATION SVCS DOES NOT CREATE A MEDICAL NECESSITY FOR AMBULANCE SVCS.

Can the patient be transported by car, taxi, bus, stretcher van or wheelchair van? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>***If YES, this patient does not meet criteria for ambulance transportation.***</i>	NYS MEDICAID ONLY	Does patient have NYS Medicaid as Primary Insurance ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is patient being discharged to home or nursing facility? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES FOR BOTH, YOU MUST CONTACT MAS FOR PRIOR AUTHORIZATION.
Is this patient bed confined? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>To be considered "bed confined," the patient must be unable to get up from bed without assistance; AND unable to ambulate; AND unable to sit up in a chair or wheelchair.</i>		MAS Niagara County 866-753-4430 (If PT is from floor/unit, Pre-Auth is required.)
		MAS Erie County 800-651-7040 MAS Genesee County 855-733-9404
		MAS PRIOR AUTHORIZATION #: _____

Describe the **PHYSICAL** or **MENTAL CONDITION** (not diagnosis) of the patient **AT THE TIME OF AMBULANCE TRANSPORTATION** that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition.

- In addition to completing the above statements, please check any of the following conditions that apply:
- Contractures Ventilator dependent IV meds/fluids required
 - Danger to self/others Patient is combative Requires restraints to prevent harm and/or injury
 - Requires isolation precautions (MRSA, VRE, etc.) Paralyzed: Hemiplegia Paraplegia Quadriplegia
 - Overall wasting and too weak to sit up in wheelchair Requires seizure precautions and monitoring
 - Requires airway monitoring or suctioning Requires continuous oxygen-unable to self-administer
 - Cardiac monitoring required during transport Hemodynamic monitoring required during transport
 - Moderate/Severe Pain on movement Unable to sit in wheelchair due to decubitus ulcers or other wounds
 - Morbid obesity requiring additional personnel/equipment to safely handle patient
 - Patient has decreased level of consciousness confused lethargic comatose
 - Patient has non-healed fractures of: cervical spine thoracic spine lumbar spine sacrum/coccyx pelvis/hip femur
 - Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
 - Other (please specify) _____

AIR AMBULANCE ONLY

- Intracranial bleeding requiring neurosurgical intervention Conditions requiring treatment in a Hyperbaric Oxygen Unit
- Burns requiring treatment at a burn center Cardiogenic Shock
- Multiple Severe Injuries Life Threatening Trauma
- Other _____
- Patient has a medical condition as described above that requires immediate and rapid transport due to the nature and/or severity of their illness/injury, and transport by ground ambulance in excess of 30 minutes would endanger the patient's life or health
- Ground ALS resources are not immediately available

AIR AND GROUND HOSPITAL TO HOSPITAL TRANSFERS

Is the patient being transferred to a higher level of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List the facilities required/available at destination facility not available at the originating facility: <input type="checkbox"/> Burn Care <input type="checkbox"/> Trauma Care <input type="checkbox"/> Cardiac Care <input type="checkbox"/> Critical Care <input type="checkbox"/> Pediatric Care <input type="checkbox"/> Other _____	
Is the patient being transported to the closest appropriate facility that can provide the required service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
***If no, why did the patient require transport to a further facility? _____	

CERTIFICATION

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 due to the reasons documented on this form. 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.

Name: _____ <small>(please print)</small>	Signature: _____
<input type="checkbox"/> MD <input type="checkbox"/> PA <input type="checkbox"/> NP <input type="checkbox"/> RN <input type="checkbox"/> LPN <input type="checkbox"/> Case Manager <input type="checkbox"/> Social Worker	NPI: _____ Date: _____