

Note : This form is to be used for **All Ambulance Transports**

AMBITRANS MEDICAL TRANSPORT, INC.



Certificate of Medical Necessity for Ambulance Transportation

Section 1 - Beneficiary Information

Print Name :	Date of Transport :	
Origin :	Medicare Number:	
Destination :	DOB :	MALE FEMALE

Section 2 - Medical Necessity Information at Time of Transport

1. Is the Patient Bed Confined as defined by Center for Medicare and Medicaid Services (unable to get up from bed without assistance, and unable to ambulate and unable to sit in a chair or wheelchair? <input type="checkbox"/> NO <input type="checkbox"/> YES
2. Can patient be transported safely in a Wheelchair Van? <input type="checkbox"/> NO <input type="checkbox"/> YES
Please check all of the following that apply : <input type="checkbox"/> EKG monitor ? <input type="checkbox"/> IV fluids or medications required during transport ? <input type="checkbox"/> Oxygen ? Requires attendant to apply, administer, or regulate oxygen during transport. <input type="checkbox"/> May require airway monitoring or suctioning ? Ventilator dependant ? <input type="checkbox"/> Requires restraints or monitoring - Patient is a danger to self or others. <input type="checkbox"/> Severe pain -Pain must be aggravated by transfers or moving vehicle such that transportation in a seated position would be dangerous to patient. <input type="checkbox"/> Requires isolation precautions. <input type="checkbox"/> Other specialized care or equipment : _____

Section 3 - Authorization of Medical Necessity

Print name of Treating physician :	DATE SIGNED :
Signature :	Printed Name:
Please circle your title : Physician, PA, Nurse Practitioner, RN, Discharge Planner involved in this patient's care .	

The Original signed form should given to Ambitrans personnel at the time of transport.

If you have any questions please contact Ambitrans at 941-629-1009 or toll free 800-881-1009 24 hours a day.