UNIT NW _____

DATE _____

TRIP # _____

PATIENT STICKER HERE

(425) 328-7651

CERTIFICATION OF MEDICAL NECESSITY

ALL FIELDS ARE REQUIRED

SECTION I

PATIENT'S LAST NAME: _____ PATIENT'S FIRST NAME: _____

PATIENT'S DATE OF BIRTH: _____

CLAIM DATE(S) SPAN BEING AUTHORIZED FOR TRANSPORTATION: _____ TO: _____

DIAGNOSES: _____

SENDING FACILITY: _____

DESTINATION: _____

*** ALL SECTIONS MUST BE FILLED OUT ***

SECTION II - Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. **Supporting documentation for any boxes checked must be maintained in the patient's medical records.**

***** CHECK ALL THAT APPLY *****

BLS - *** Basic Life Support Requirements ***

- ☐ Bed confined - all three must be met. Unable to ambulate; Unable to get out of bed without assistance; Unable to safely sit up in a wheelchair
- ☐ Third party assistance/attendant required to apply, administer, regulate, and/or adjust oxygen en route
- ☐ Unable to sit in a chair or wheelchair due to GRADE II or greater decubitus ulcer on buttocks
- ☐ Special handling en route - isolation
- ☐ Contractures ☐ Upper ☐ Lower ☐ Left ☐ Right
- ☐ Non-healed fractures ☐ Upper ☐ Lower ☐ Left ☐ Right ☐ Location: _____
- ☐ Moderate to severe pain on movement
- ☐ DVT requires elevation of lower extremity
- ☐ Morbid obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc) requiring special handling in transit
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others (monitoring and/or flight risk)
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Altered level of conciousness: ☐ Confused ☐ Combative ☐ Lethargic ☐ Comatose
- ☐ I.V. fluids NS or LR at set infusion rate without I.V. pump
- ☐ Higher level of care: _____
- ☐ No inpatient beds at sending facility

ALS - *** Advanced Life Support Requirements ***

(BLS requirements may also be checked in addition to ALS requirements if needed)

- ☐ Cardiac monitoring required during transport) 4 lead, 12 lead, externally paced, pacer pads, pacemaker)
- ☐ Hemodynamic monitoring ☐ Arterial line ☐ CVP ☐ Balloon pump ☐ ECMO
- ☐ Intubated ☐ Ventilator ☐ BIPAP ☐ CPAP ☐ Tracheostomy with airway suction
- ☐ Chest tubes ☐ NG tube
- ☐ Symptomatic hypertension/hypotension, syncope
- ☐ I.V. medications/fluids (antibiotic infusions, blood products, cardiac medications, dextrose, electrolyte replacement, insulin drip, narcotics)

SECTION III

PROVIDER'S AUTHORIZATION

** I certify that the inofrmation contained above represents an accurate assessment of the patient's medical condition on the date of service **

_____ PROVIDER'S SIGNATURE

_____ PRINTED NAME

_____ DATE

CHECK ONE: ☐ PHYSICIAN ☐ PA ☐ RN ☐ NP ☐ CNS ☐ DCP ☐ LPN ☐ SOCIAL WORKER ☐ CASE MANAGER

This authorization must be completed and signed by the attending physician for scheduled repetitive transports. For unscheduled non-repetitive transports, the authorization may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practicioner, registered nurse, licensed practical nurse, social worker, case manager, or discharge planner (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.