



MedEvac

CERTIFICATE OF MEDICAL NECESSITY FOR AMBULANCE TRANSPORT

SECTION I TRANSPORT INFORMATION

Patient Name: \_\_\_\_\_ Transport Number: \_\_\_\_\_
Date of Service (ground repetitive transports may be authorized for 60-day date range): \_\_\_\_\_
Transported From: \_\_\_\_\_ Transported To: \_\_\_\_\_
Sending Physician: \_\_\_\_\_ Receiving Physician: \_\_\_\_\_

SECTION II REASONABLENESS FOR TRANSFER OF PATIENT FROM ONE FACILITY TO ANOTHER

- Service not available at originating facility (select all that apply or describe in 'Other'):
() Cardiac Specialty Services () Pulmonary Services () Interventional or Neurosurgical Services
() Comprehensive Stroke Care () High-Risk OB () Pediatric Specialty/NICU
() Trauma/Burn Services () Surgical Specialty \_\_\_\_\_ () ICU Care needed
() Subspecialty Intervention \_\_\_\_\_ () Specialized Services \_\_\_\_\_ () Other \_\_\_\_\_

SECTION III REASON FOR DESTINATION CHOICE

- Reason for destination choice (select all that apply or describe in 'Other'):
() Specialty Service or Intervention not available at any closer, capable facility
() Admission/Bed for necessary intervention not available at any closer facility
() Medically necessary transfer per referring provider request
() Medically necessary transfer however Patient / Family requested specific destination for preferred specialist
() Medically necessary transfer and Health Insurance determines destination / preferred provider
() Not Medically necessary transfer but Patient / Family request for transfer
() Leave of Absence(LOA) Medically necessary transfer for a procedure/treatment with planned transfer back to originating facility
() Other \_\_\_\_\_

SECTION IV REASON FOR TRANSPORT BY AMBULANCE

GROUND AMBULANCE Describe the patient's medical condition at time of transport (physical/mental) that would require monitoring or intervention enroute: \_\_\_\_\_

Select all that Apply:

- ( ) IV Medications/Fluids EnRoute ( ) Contractures/Non Healed Fractures ( ) Patient is Confused/Altered Level of Consciousness
( ) Hemodynamic/Tele Monitoring EnRoute ( ) Patient is Sedated/Comatose ( ) Patient Requires Restraints
( ) Requires Oxygen - Unable to Self-Regulate ( ) Patient is a Danger to Self or Others ( ) Patient is Combative
( ) Moderate/Severe Pain ( ) DVT/Contractures Special Positioning ( ) Orthopedic Device/Positioning
( ) Isolation Precautions / Infection Control ( ) Morbid Obesity Requires Special Equipment/Extra Personnel

AIR AMBULANCE Describe detail about the patient condition that deems Air Ambulance, versus Ground Ambulance, medically necessary: \_\_\_\_\_

Select All that Apply:

- ( ) Time Sensitive Intervention Required
( ) Distance to Intervention, and the time of ground transport travel, is excessive & potentially detrimental to the patient's outcome (greater than 30 to 60 minutes travel time via ground)
( ) No Ground Ambulance Resource Available
( ) Ground Ambulance transport Obstacles or Conditions that would prolong transport time to Urgent Intervention
Weather \_\_\_\_\_ No Ground Resource \_\_\_\_\_ Road /Traffic Conditions \_\_\_\_\_ Disaster Situation \_\_\_\_\_

SECTION V REFERRING HEALTHCARE PROVIDER SIGNATURE

Emergency Air or Ground Ambulance Transports, or Non-Emergency/Non-Repetitive Ground Ambulance Transports, may be signed by these Authorized Healthcare Professionals: Physician, PA, NP, CNS, RN, LPN, Social Worker, or Case Manager
Non-Emergency/Repetitive Ground Ambulance Transports require the Attending Physician Signature

REFERRING HEALTHCARE PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINTED NAME & CREDENTIALS \_\_\_\_\_