AMERICAN EMS

Physician Medical Necessity Certification

Medicare requires via 42 CFR part 424.36 (b) (4) that AMERICAN EMS obtain a certificate of medical necessity signed by the patient's physician prior to providing any non-emergency ambulance transportation. This form provides the information needed to make medical necessity determinations for non-emergency ambulance transportation. The completed form should be given to AMERICAN EMS personnel at the time of transport, or you may fax form direct to AMERICAN EMS billing department 770-489-2132.

Instructions: Please complete all sections of this form and have the patient's physician sign the form prior to transport. *(PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)*

SECTION 1 – BENEFICIARY INFORMATION		Transport Date:	
Last Name:	First Name:	MI:	DOB: / /
SSN: - -	Origin:		
Medicare #	Destination:		

SECTION 2 – MEDICAL NECESSITY INFORMATION *(to be completed by Authorized Personnel)*

PLEASE CHECK ALL THAT APPLY

□ ***Bed Confined*** - The patient is: (all three conditions must apply), unable to get up from bed without assistance; and, unable to ambulate; and, unable to sit in a chair or wheelchair.

□ ***Stretcher Only*** - Other means of transportation are contraindicated because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. Significant medical conditions must accompany these claims:______________________________

□ ***Psychiatric*** assistance and/or restraints due to patient and/or others safety: *Alzheimer's, Disoriented, psychosis, schizophrenia, dementia, or psychiatric behavior*. List condition(s) which necessitates the transport: ____________________

PLEASE CHECK ALL THAT APPLY

□ Contractures	□ Paralysis	□ Patient is confused
□ Non-healed fractures	□ Hemodynamic monitoring required	□ Patient is combative
□ Moderate/severe pain	□ Cardiac monitoring required	□ Danger to self/others
□ DVT requires elevation	□ IV meds/fluids required	□ Possible need/Need for restraints
□ Infection control precautions	□ Unable to self-administer O2	□ Seizure prone/monitor
□ Hip Replacement	□ Medical attendant required	□ Patient is comatose

□ Frail, debilitated, risk of falling out of wheelchair
□ Abnormal gait; lack of coordination
□ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds: *Back: Stg____; Hip Stg____; Buttock Stg____*
□ Morbid obesity requires additional personnel/equipment to safely handle patient
□ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
□ Unable to tolerate seated position for time needed to transport
□ Movement by draw sheet
□ Requires 2-man lift
Other EXPLAIN: ______________________________

SECTION 3 – AUTHORIZATION (in accordance with Georgia Medicare Rules & Regulations concerning Ambulance Service.) The attending physician must sign this form. If the physician is unavailable 42 CFR 424.36 (b)(4) allows this form to be signed by either a physician's assistance, nurse practitioner, clinical nurse specialist, registered nurse or discharge planner who has personal knowledge of the beneficiary's condition at time of ambulance transport.

Name of the Medical Personnel Attesting to the Medical Necessity: UPIN____________________

Printed Name ______________________________ Title____________________

Signature______________________________ Date____________________

For questions regarding this form please call (770) 489-2131, Fax (770) 489-2132, or email info@aemsga.com