

MEDXPRESS

E.M.S.

PCS

PCS REQUIRED FOR MEDICARE RECIPIENTS: 1 - ALL HOSPITAL DISCHARGE. 2 - ALL NON-EMERGENCY TRANSPORTS. 3- ALL HOSPITAL TO HOSPITAL TRANSPORTS.

PCS NOT REQUIRED FOR MEDICARE RECIPIENTS: 1 - TRANSPORT TO AND FROM DR'S OFFICE. 2 - TRANSPORTS TO CLINICS. (MEDICARE DOES NOT COVER TRANSPORTATION TO AND FROM DR'S OFFICES AND CLINICS.)

CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORTATION AS REQUIRED BY MEDICARE

PATIENT NAME

VALID DATES (FROM - To)

MEDICARE #

NO PAYMENT MAY BE MADE FOR AMBULANCE SERVICES WHERE SOME OTHER MEANS OF TRANSPORTATION, OTHER THAN AN AMBULANCE, COULD BE UTILIZED WITHOUT ENDANGERING INDIVIDUAL'S HEALTH, WHETHER OR NOT SUCH OTHER TRANSPORTATION IS AVAILABLE. MEDICAL NECESSITY IS ESTABLISHED WHEN THE PATIENT'S CONDITION, NOT THE DIAGNOSIS, MAKES THE USE OF ANY OTHER METHOD OF TRANSPORTATION CONTRAINDICATED. THE AMBULANCE ENVIRONMENT MUST OFFER SOMETHING THAT WOULD SIGNIFICANTLY IMPROVE THE SAFETY AND HEALTH OF THE PATIENT.

AMBULANCE TRANSPORTATION IS MEDICALLY NECESSARY FOR THE FOLLOWING REASONS:

CHOOSE ONLY ONE WORKSHEET ON REVERSE SIDE	<input type="radio"/> 1. BED RIDDEN. FOR MEDICARE PURPOSES, THIS MEANS COMPLETELY CONFINED TO A BED AND UNABLE TO TOLERATE ANY ACTIVITY OUT OF BED. ALL THREE OF THE FOLLOWING MUST APPLY FOR A PATIENT TO BE CONSIDERED BED CONFINED. 1) UNABLE TO GET UP FROM BED WITHOUT ASSISTANCE. 2) UNABLE TO AMBULATE AND 3) UNABLE TO SIT IN A CHAIR OR WHEELCHAIR.
	<input type="radio"/> 2. 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 DOCUMENTATION MUST ACCOMPANY THESE CLAIMS. COMPLETE WORKSHEET ON THE BACK.
	<input type="radio"/> 3. AMBULANCE TRANSPORTATION IS NOT MEDICALLY NECESSARY.

SIGNATURE OF ATTESTATION

NAME: PLEASE PRINT

DATE

CHOOSE ONLY ONE	<input type="radio"/> PHYSICIAN	<input type="radio"/> PHYSICIAN ASSISTANT	<input type="radio"/> REGISTERED NURSE
	<input type="radio"/> NURSE PRACTITIONER	<input type="radio"/> DISCHARGE PLANNER	

UNDER HCFA TRANSMITTAL 8-00-09, THIS FORM IS REQUIRED ON NON-EMERGENCY TRANSPORTS PROVIDED TO MEDICARE RECIPIENTS. SIGNATURE OF ATTESTATION CAN BE OBTAINED FROM A PHYSICIAN, PHYSICIAN ASSISTANT, REGISTERED NURSE, NURSE PRACTITIONER, OR DISCHARGE PLANNER WITH STAFF PRIVILEGES OR EMPLOYED BY TREATING FACILITY AND HAS KNOWLEDGE OF THE BENEFICIARY'S CONDITION.

MEDICAL NECESSITY VERIFICATION GUIDE

BASED ON GUIDELINES SET FORTH BY CMS FOR AMBULANCE PROVIDERS

PHYSICAL LIMITATIONS		
GENERAL DISABILITIES (PHYSICAL CONDITION)		
CHECK ALL THAT APPLY AND CIRCLE SPECIFIC CHOICE WHERE APPLICABLE		
Paralysis	Amputations	Fractures/Dislocations
Hemiplegia: Left Right	AKA: Left Right Bilateral	Hip: Left Right
Paraplegia: Upper Lower	BKA: Left Right Bilateral	Femur: Left Right
Quadruplegia	High AKA: Left Right Bilateral	Pelvis
Other:	Other:	Spine: (site)
Paresis	Contractures	Date of Fracture: / /
Hemiparesis: Left Right	Arm: Left Right Bilateral	Surgical Repair: / /
Paraparesis: Left Right	Describe:	Inoperable
Quadruparesis:	Leg: Left Right Bilateral	Non resolved
Other:	Describe:	Unstable Fracture
Wounds	Spine:	Describe:
Coccyx: Stage	Describe:	
Sacrum: Stage	Fetal Position	Other Physical Limitations
Buttock: LT RT Stage	Foot Drop: Left Right Bilateral	Weight: _____ LB or KG
Hip: LT RT Stage	Rigid Extremities:	Height: _____
Non healing wound (site):	Other:	Other: _____
Surgical incision		

SECONDARY CONDITIONS		
CONDITIONS THAT ILLUSTRATE PATIENT'S DISABILITY RESULTING FROM PHYSICAL LIMITATIONS		
CHECK ALL THAT APPLY AND CIRCLE SPECIFIC CHOICE WHERE APPLICABLE		
Unable to ambulate	Alterations in cognition	Hallucinations or paranoia
Unable to get out of bed	Short term memory loss	Homicidal or suicidal
Unable to sit in chair unassisted	Unresponsive to pain and voice	Foley or supra pubic catheter
Chronic GCS < 14	Combative or agitated behavior	Incontinent diaper/brief
Extremity requires elevation	Inability to follow commands	Feeding tube: PEG PEJ NJ
Sitting contraindicated (Why?)	Unmanageable behavior	Late stage of terminal cancer / disease
Completely immobile	Danger to self/others	Special handling: isolation
Restraints (to prevent falling)	Sedation (chemical restraints)	Special handling: To avoid further injury
Requires extensive or total care for ADL's	Restraints (to prevent harm to self or others)	Special handling: Orthopedic device / immobilizer

PRIMARY CONDITIONS
PATIENTS MUST MEET AT LEAST ONE OF THESE
CHECK ALL THAT APPLY
Bed Confined: Unable to get out of bed, unable to ambulate, and unable to sit.
Postural Instability: Unable to maintain an upright seated position unassisted/unattended/unrestrained.
Non Weight Bearing Condition: Any condition affecting the weight bearing parts of the body that would prevent the patient from traveling in a seated position (spine, hips, pelvis, buttocks, sacrum, femur).

MEDICAL DIAGNOSIS/HISTORY

HOSPITAL TO HOSPITAL TRANSFERS (CHECK SERVICE NOT AVAILABLE AT SENDING FACILITY)
<input type="radio"/> LTAC <input type="radio"/> Inpatient Physical Rehab <input type="radio"/> Skilled Nursing Facility
Other: (specify) _____

IF PATIENT ADMITTED TO HOSPICE CARE AT THIS TIME:
NAME OF HOSPICE COMPANY: _____
NAME OF ADMIT DIAGNOSIS: _____

SPECIAL BILLING INSTRUCTIONS
BILL TO: _____
AUTHORIZED BY: _____
TITLE: _____

FORM COMPLETED BY: _____

FACILITY MEDICAL RECORD NUMBER: _____

PRINT PATIENT NAME: _____

DATE OF SERVICE: ____ / ____ / ____