



Ambulance

Certification of Medical Necessity

1. Patient's Name
2. Patient's Address
3. Patient's Medicaid Billing Number
4. Ambulance Medicaid Provider Name COMMUNITY AMBULANCE
5. Ambulance Medicaid Provider Number 0990594

6. Date(s) of (First) Transport

7. Why must the patient use an Ambulance instead of other types of transport? (Check One)

- Non-ambulatory** The patient is non-ambulatory and is unable to get up from bed without assistance. The patient is unable to sit in a chair or wheelchair and the patient can only be moved by a stretcher or needs to be restrained.
- Medical Supervision** Patient requires continuous medical supervision or treatment during transport.
- Oxygen Administration** Patient requires oxygen administration during transport and the patient is unable to self-administer or self-regulate the oxygen or the patient requiring oxygen administration has been discharged from a hospital to a nursing facility.

8. What medical condition requires the patient to use an Ambulance?

Please describe the patient's medical condition that requires the patient to use an ambulance in terms that an average person could understand. The description of the patient's medical condition should support the item(s) checked in number 7.

9. How long may the patient require an Ambulance for transportation?

- Temporary** (not to exceed 90 days) Patient is expected to need an Ambulance for transport for days from the date of first transport because of the reason(s) checked in number 7 and the medical condition(s) identified in number 8. This certification form is valid for the estimated length of time as designated by the attending practitioner.
- Permanent** The patient is expected to need an Ambulance for transport for at least 365 days from the date of the first transport.

10. Are there any other comments or explanations? (Optional)

11. Who is the attending practitioner that has ordered the Ambulance transport?

A. Attending Practitioner ordering this medical transport: (Please Print Name)

B. Attending Practitioner Provider Number (Do not use 9111115)

12. Who is the attending practitioner or R.N /discharge planner that is signing?

A. Signature & Professional Letters (i.e. MD, DO, RN, APN, LSW etc.)

B. Signature Date