MEDIC
Medical Excellence. Compassionate Care.

REQUIRED - FAX **COMPLETED** FORM TO 704.943.6192

PATIENT INFORMATION (OR STICKER)

Patient Name: _____ Today's Date: _____ Promised Time: _____

Patient DOB: _____ Pick Up Date: _____ Appt Time: _____

Patient SSN: _____ Preferred Phone: _____ Requested Pick Up Time: _____

Person Requesting: _____

Diagnosis: _____ What is the medical reason for the transport? _____

What is the reason why an ambulance is required? _____

Why would transport (by any other means) be harmful to patient? _____

Pick Up Location: _____ Phone: _____ P / U Room #: _____

Destination: _____ Phone: _____ Room #: _____

Address: _____ Facility: _____ C/S/Z: _____ MD Name: _____

Special Equipment Needs: ☐ IV ☐ Monitor ☐ O2 ☐ Vent / Trach

Weight = _____ lbs Is patient in bariatric bed in your facility? ☐ Y ☐ N

Other: _____

Will patient need lifting assistance? ☐ Y ☐ N _____

Vital signs: BP: _____ / _____ HR: _____ Resp: _____ Temp: _____ Blood Sugar: _____

IV Meds: ☐ Y ☐ N Please describe:

Comunicable Disease(s): ☐ Y ☐ N Please describe:

BILLING INFORMATION

Is this a round trip transport to/from the originating facility? ☐ Y ☐ N **If yes: A form is required for EACH transport**

If yes:

Is the Service not available at original facility? Describe service needed: _____

The facility will be billed for this transport. HOSPITAL ACCOUNT NUMBER: _____ DEPT: _____

Is this patient from a skilled nursing facility? ☐ Y ☐ N

If yes, is the patient in the Part A period (1st, 100 days of stay) ☐ Y ☐ N

If yes, what service is the transported patient to receive: _____

The SNF will be responsible for the transport. SNF ACCOUNT NUMBER: _____ DEPT: _____

If no

Is the patient an In-Patient at the hospital? ☐ Y ☐ N

If yes, are they being discharged from this hospital? ☐ Y ☐ N

Why is the patient being transported to another facility? _____

Is the receiving facility the closest appropriate facility available to provide the care needed for the patient? ☐ Y ☐ N

PHYSICIAN CERTIFICATION STATEMENT (PCS)

A PCS is required for all transports. Is the PCS attached? ☐ Y ☐ N

INSURANCE

Medicaid: _____ Medicare #: _____ Insurance Co/Responsible Party: _____

Insurance Company Authorization#: _____ **Date Obtained**: _____

Mailing Address: _____

Policy / P.O. Number: _____ Insurance Company Phone #: _____

REQUIRED - ALL OUT OF COUNTY TRANSPORTS

Who from your facility will be financially responsible for authorizing this transport, IF coverage is denied:

Name: _____ Department: _____ Phone #: _____

I certify that the information provided in this form is complete, accurate and supported in the aforementioned patient's medical records -to the best of my knowledge. The information being utilized on this form is being gathered to assist in seeking reimbursement from third party payers or the Medicare Program.

Signature: _____ Name (printed): _____ Date: _____

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REQUIRED - FAX TO 704.943.6192 TO SCHEDULE TRANSPORT

A Physician Certification Statement (PCS) is required for all Medicare patients being transferred or discharged from a hospital, skilled nursing facility, or transported from a skilled nursing facility for an outpatient visit to a physician's office, outpatient clinic, or other medical facility if the appointment is scheduled non-emergency, or non-scheduled non-emergency.

Patient's Name: _____ Sex: ☐ M ☐ F DOB: _____

PHYSICIAN CERTIFICATION STATEMENT

In order to meet medical necessity the patient must meet one or more of the following four criteria.
Transportation by ambulance is needed for this patient for the following reasons:

1. Bed confined at the time of transport
(All must apply if checked):

☐ Unable to ambulate, unable to get up without assistance and unable to sit in a chair or wheelchair.

2. ALS monitoring required
(Check applicable condition):

☐ Cardiac/hemodynamic
☐ Advanced Airway Management
☐ IV meds required
☐ Chemical Restraint

3. Monitoring is required:

☐ Suction
☐ Airway control/positioning
☐ Third Party Assistance

4. Medical Conditions that contraindicate transport by other means:
(Check applicable conditions):

☐ Patient Safety-danger to self or others
☐ Needs Medical Observation
☐ Communicable disease
☐ Contractures
☐ Hazardous material exposure
☐ Morbid obesity
☐ Special handling to avoid further injury. Explain: _____
☐ Unable to be transported in seated position due to **decubitus ulcers stage** _____ of buttocks, coccyx, hip, sacrum and stage
☐ Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures
☐ Paralysis: ☐ hemi ☐ para ☐ quad
☐ Fracture of the _____
☐ Unsafe to be transported in seated position due to _____
☐ Other pertinent medical conditions _____
☐ If patient is unable to ambulate, walk or sit without assistance, please explain why? _____

_____

Only a Physician can sign for Repetitive Patients. Repetitive Patient is defined as transported for same condition once a week for 3 consecutive weeks or 3 times in a 10 day period.

I certify that our institution has furnished care or other services to the above named patient. In the event that you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf. This signature is not an acceptance of financial responsibility for the patient.

Physician's Signature: _____

Physician's Name (please print or type): _____

***Signature:** _____ **Date:** _____

***Non-Repetitive Patients (check one)**: ☐ MD ☐ RN ☐ Discharge Planner ☐ Nurse Practitioner ☐ Clinical Nurse Specialist