

**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: \_\_\_\_\_  
Communicable 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 (1<sup>st</sup>, 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

**CERTIFICATION STATEMENT (PCS OR NPCS)**

A CERTIFICATION STATEMENT 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: \_\_\_\_\_

A Certification Statement 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: \_\_\_\_\_

**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:

<p><b>1. Bed confined at the time of transport</b> (Complete question 4N, if all conditions apply below):</p> <p><input type="checkbox"/> Unable to ambulate, unable to get up without assistance and unable to sit in a chair or wheelchair.</p>	<p><b>2. ALS monitoring required</b> (Check applicable condition):</p> <p><input type="checkbox"/> Cardiac/hemodynamic  <input type="checkbox"/> Advanced Airway Management  <input type="checkbox"/> IV meds required  <input type="checkbox"/> Chemical Restraint</p>	<p><b>3. Monitoring is required:</b></p> <p><input type="checkbox"/> Suction  <input type="checkbox"/> Airway control/positioning  <input type="checkbox"/> Third Party Assistance</p>
---	---	--

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

a. Patient Safety-danger to self or others  
 b. Needs Medical Observation  
 c. Communicable disease  
 d. Contractures  
 e. Hazardous material exposure  
 f. Morbid obesity  
 g. Special handling to avoid further injury. Explain: \_\_\_\_\_  
 h. Unable to be transported in seated position due to **decubitus ulcers stage** \_\_\_\_\_ of buttocks, coccyx, hip, sacrum and stage  
 i. Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures  
 j. Paralysis:  hemi  para  quad  
 k. Fracture of the \_\_\_\_\_  
 l. Unsafe to be transported in seated position due to \_\_\_\_\_  
 m. Other pertinent medical conditions \_\_\_\_\_  
 n. 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 (one MUST be checked):  MD  RN  LPN  Discharge Planner  Nurse Practitioner  
 Clinical Nurse Specialist  Social Worker