

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 (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

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>1. Bed confined at the time of transport (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>2. ALS monitoring required (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>3. Monitoring is required:</p> <p><input type="checkbox"/> Suction <input type="checkbox"/> Airway control/positioning <input type="checkbox"/> Third Party Assistance</p>
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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