MEDIC
Mecklenburg EMS Agency

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

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: ____________

REQUIRED - FAX TO 704.943.6192 TO SCHEDULE TRANSPORT

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:

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

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**: ☐ MD ☐ RN ☐ LPN ☐ Discharge Planner ☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Social Worker ☐ Physician Assistant ☐ Case Manager

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