

**STOP - If this patient has Medicaid Managed Care, please contact the appropriate transport broker to schedule a transport.**



WellCare: MTM 877-598-7602 ■ United Healthcare: ModivCare 855-397-3604 ■ Health Blue: ModivCare 855-397-3602  
 ■ AmeriHealth Caritas: Member Services 855-375-8811 ■ Carolina Complete: ModivCare 855-397-3601 ■

**TRANSPORTATION INFO**

Pick Up Date: P/U Facility Name: P/U Facility Phone:  
Requested P/U Time: P/U Address: P/U Room #:  
Appt Time:  
Promised Time: Dest. Name: Dest. Phone:  
Person Req'ing: Dest. Address: Dest. Room #:  
Preferred Phone:

**PATIENT INFORMATION (OR STICKER)**

Patient Name: Diagnosis:  
Patient DOB: What is the medical reason for the transport?  
Patient SSN:

What is the reason why an ambulance is required?  
Why would transport (by any other means) be harmful to the patient?

C/S/Z: MD/DO NAME:

**PATIENT CLINICAL INFO AND SPECIAL CONSIDERATIONS**

<u>Special Equipment Needs:</u>	<u>IV</u>	<u>Cardiac Monitor</u>	<u>Oxygen</u>	<u>Vent/Trach</u>
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Weight = Is the patient in a bariatric bed in your facility? Yes No

Will patient need lifting assistance? Yes No Other Considerations:

**VITAL SIGNS**

B/P: / HR: Resp: Temp: Blood Sugar:

IV Medications: Yes No If "Yes" please describe:

Communicable Disease(s): Yes No If "Yes" please describe:

**BILLING INFORMATION**

Is this a round trip transport to/from the originating facility? Yes No **If "Yes": A form is required for EACH transport**

If "Yes": Is the Service not available at original facility? Yes No Describe service needed:

The facility will be billed for this transport Hospital Account # DEPT:

Is the patient from a skilled nursing facility? Yes No  
If "Yes", is the patient in the "Part A" period (1<sup>st</sup>, 100 days of stay) Yes No

If "Yes", what service is the transported patient to receive?  
 The facility will be billed for this transport SNF Account # DEPT:

If "No": Is the patient an In-Patient at the hospital? Yes No If "Yes", are they discharged from the hospital? Yes No

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? Yes No

**CERTIFICATION STATEMENT (PCS OR NPCS)**

A CERTIFICATION STATEMENT is required for all transports. Is the PCS attached? **Yes** **No**

**INSURANCE**

Medicaid#: Medicare#: Insurance Co/Resp. Party: Insurance Co. Auth#

Date Obtained: Mailing Address:

Policy / P.O. # Insurance Co/Resp. Party Phone #

**REQUIRED**-Is the destination facility the closest for service? **Yes** **No**

If "Yes", please explain why this facility is the closest appropriate:

If no, who from your facility will be financially responsible for authorizing this transport, if denied by insurance.

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: Male Female Date of Birth:

**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>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>Cardiac/hemodynamic Advanced Airway Management IV meds required Chemical Restraint</p>	<p><b>3. Monitoring is required:</b></p> <p>Suction Airway control/positioning 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** sacrum and stage of buttock, coccyx, hip
  - i. Positioning in wheelchair or standard car seat inappropriate due to contracture 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.

Non-Physician's Signature Date:

Non-Physician's Name (please print or type)

\*\*\*Physician's Signature: Date:

\*\*\*Physician's Name (please print or type)

Please check the appropriate box for above signature: MD NP PA RN LPN Discharge Planner  
Social Worker Case Manager Clinical Nurse Specialist