MEDICAL NECESSITY CERTIFICATION STATEMENT
FOR AMBULANCE TRANSPORT

TRI-MED

Run # _____

Phone # (206) 988-5000

Fax # 206-243-0756

Date of Transport: _____
(Repetitive trips require the signature of the attending **physician**; expires a maximum of 60 days after physician's signature)

Patient's Last Name:_____
Patient's First Name: _____ MI: _____
Gender (circle one): M / F DOB: _____ Medicare #: _____

Transport From:	
Transport To:	
Primary Diagnosis:	
Secondary Diagnosis:	

Is this patient "bed confined" as defined below? ☐ Yes ☐ No

To be "bed confined" the patient must satisfy all three of the following criteria: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

The minimum safe level of transportation:

☐ BLS (Any means other than a fully equipped BLS ambulance could have endangered the patient's health)

☐ Critical Care (Any means other than a fully equipped ALS ambulance with minimum 1 RN & 1 EMT could have endangered the patient's health)

Other means of transport are contraindicated based on the following condition(s) requiring ambulance transport:

☐ Requires continuous oxygen (unable to self-administer)
☐ Requires airway monitoring
☐ Patient is ventilator dependent
☐ Requires EKG monitoring
☐ Has continuously running intravenous device
☐ Requires isolation procedures (VRE, MRSA, etc.)
☐ Cannot safely support themselves in a wheelchair
☐ Requires medical supervision during transport (explain below)
☐ Is comatose or obtunded, requiring trained monitoring
☐ Has decubitus ulcers and requires wound precautions
☐ Unable to get out of bed safety with one person assisting
☐ Other (explain below)

Explain/elaborate on conditions (not necessarily diagnoses) which necessitate ambulance transport:

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40 are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

Signature	Date
Print Name	Title

☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner ☐ Registered Nurse ☐ Licensed Practical Nurse
☐ Case Manager ☐ Social Worker ☐ Discharge Planner ☐ Clinical Nurse Specialist

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