BELL AMBULANCE
264-BELL
(414-264-2355)

"IF IT DOESN'T SAY BELL ON THE SIDE, YOU'VE JUST BEEN TAKEN FOR A RIDE!!!"®

MEDICAL NECESSITY CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORT

COMPLETELY DOCUMENT ALL THAT APPLY AND BE SPECIFIC

Client Name: _____ Date of Transport: _____

From: _____ To: _____

❑ **ROUND TRIP** transport on the same day, PCS applies to both transports.

In my professional opinion, this patient requires transport by ambulance and should not be transported by other means for the reasons listed below:

❑ **IMMOBILIZED** due to recent fracture or possible fracture:

❑ HIP ❑ LEG ❑ NECK ❑ OTHER: _____

❑ **CONTRACTED** and **CANNOT** sit up in a wheelchair:

❑ Upper Extremities ❑ Lower Extremities ❑ Fetal

❑ Suffers from **PARALYSIS**: ❑ Para ❑ Quad ❑ Hemi

❑ **NOT WHEELCHAIR ABLE**
(Risk of falling off wheelchair or stretcher while in motion.)
Reason(s): ❑ Poor Trunk Control ❑ Postural Instability
❑ Spastic / Jerking movement ❑ Fetal position
❑ Other: _____

❑ Is **BED-CONFINED** i.e.: Patient unable to get up from bed without assistance **and** unable to ambulate **and** unable to sit in chair or wheelchair. **(MUST meet all three criteria in order to meet definition of bed confined)**

Please Explain: _____

❑ Requires **TRAINED MONITORING** by EMT/Paramedic for:
❑ Airway control/positioning or suctioning
❑ Continuous IV therapy
❑ Ventilator dependent / advanced airway monitoring
❑ Cardiac monitoring
❑ Is medicated and requires monitoring
❑ Danger to self or others
❑ Acute Condition: Explain: _____

❑ Requires **RESTRAINTS**
❑ Physical - Type: _____ ❑ Chemical - Type: _____
Reason:
❑ to maintain upright position ❑ to prevent from falling
❑ prevent from injury to self or others ❑ flight risk

❑ **MORBID OBESITY** Patient Weight: _____
Additional personnel required? ❑ Yes ❑ No How Many: _____

❑ **AMPUTATIONS** and CANNOT sit up in wheelchair:

❑ Right ❑ Left ❑ Bilateral ❑ Above knee ❑ Below knee

❑ **SEVERE PAIN** Pain Scale (1-10): _____
(Pain must be aggravated by transfers or moving vehicle such that trained expertise of EMT required.)
Detailed Explanation: _____

❑ Has **DECUBITUS ULCERS**: Size: _____ Stage: _____
Location: ❑ Buttocks ❑ Coccyx ❑ Hip ❑ Other: _____

❑ Requires **OXYGEN** enroute.
Does patient have his or her own portable oxygen? ❑ Yes ❑ No
Is patient able to administer his or her own oxygen? ❑ Yes ❑ No
If No, WHY: _____

❑ Requires **ISOLATION PRECAUTIONS**
Why: _____

❑ Patient has **ALTERED MENTAL STATUS**
Is this condition: ❑ New Onset ❑ Normal Status ❑ Status Change
Does the patient exhibit: ❑ Hostile ❑ Agitated
❑ Violent ❑ Non-Compliant

❑ Patient exhibits a **DECREASED LEVEL OF CONSCIOUSNESS**
❑ Unconscious ❑ Semi-conscious, stuporous
❑ Syncope ❑ Seizure prone
❑ Unresponsive ❑ Intermittent consciousness
❑ Incoherent ❑ Hallucinating
❑ Lethargic ❑ Head injury with altered mental status

FACILITY TO FACILITY TRANSPORTS **REASON FOR TRANSFER – CHOOSE ONE**:

❑ Services are not available at originating facility. What services: _____

❑ Insurance Request ❑ Physician Request / Convenience ❑ Patient / Family Request

Level of Service requested by physician: ❑ BLS ❑ ALS ❑ Critical Care/SCT

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand That this information will be used by the Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

Signature of Healthcare Professional: _____ Date: _____

Printed Name: _____ Title: ❑ M.D. / D.O.
❑ RN / LPN
❑ Discharge Planner
❑ Nurse Practitioner
❑ PA
❑ Clinical Nurse Specialist
❑ Case Manager / Social Worker