RAPID RESPONSE®

Please place patient label here

A Team for Life!

Dispatch Center: (877) 797-9900

Physician's Certificate of Medical Necessity

Ambulance Transportation Form

For all non-emergent ambulance transports:
Insurance carriers require a <u>physician's summary and signature</u> certifying that this patient fulfills the medical necessity requirements for stretcher transportation by ambulance. This means the patient cannot be transported by wheelchair van, taxi cab, or private car because it would endanger the patient's health.

Date of Service: ____________________

Patient Printed Name: ____________________

Transferring Facility: ____________________

Receiving Facility: ____________________

☐ And Return

For hospital to hospital transfers please indicate the services transferring facility cannot provide:

If services can be provided at the initial hospital, transportation to another hospital is usually not covered by insurance.

☐ Burn unit required
☐ Specialized diagnostics or surgery (describe below)
☐ Inpatient psychiatric services
☐ Specialized pediatric services (describe below)

____

____

Please check all that apply to the patient's condition:

☐ Unable to sit in a wheelchair for periods greater than 15 minutes because of: ____________________

☐ Unable to stand and pivot without assistance due to: ____________________

☐ Severely decreased level of consciousness due to: ____________________

☐ Oxygen administration or portable ventilator, patient unable to self-administer due to: ____________________

☐ Monitoring of prescribed I.V. medication(s) by portable I.V. pumps (ALS service only)

☐ Cardiac monitoring ECG

☐ Airway monitoring and suctioning

☐ Physical restraining (leather, soft or Posey restraint and/or sedation) required to prevent elopement, and or injury to patient or others.

☐ Bedridden due to: ☐ Atrophy ☐ Paralysis ☐ Other: ____________________

☐ Chemical sedation requiring monitoring
☐ ALS for precautions (describe below)

☐ Wound precautions (decubitis ulcer or bed sore)
☐ Maintenance of IV fluids or port
☐ Psychosis / Flight Risk

Supporting Diagnosis: ____________________

Other Narrative: ____________________

PLEASE SIGN

Physician Signature: X ____________________

Physician Printed Name: X ____________________

Additional copies of this form may be obtained from our website at: RREMS.NET