



DANE 608-270-1111 Nationwide Toll-Free: 866-525-8888

Certificate of Medical Necessity (CMN) for Non-Emergent Ambulance Transport
A CMN is required for non-emergency ambulance transports to establish medical necessity.

REV C-2017

Transport Date: \_\_\_\_\_ Origin: \_\_\_\_\_ Destination: \_\_\_\_\_

Patient's Name (print): \_\_\_\_\_ Physician: \_\_\_\_\_

Certificate of Medical Necessity for Repetitive Ambulance Transport: Complete on reverse side.

In my professional opinion, this patient requires transport by ambulance and should not be transported by other means for one or more of the following reasons:

- Checkboxes for medical conditions: BED-CONFINED, RESTRAINTS, DECUBITUS ULCERS, OXYGEN, ALTERED MENTAL STATUS, DECREASED LEVEL OF CONSCIOUSNESS, etc.

Hospital-to-Hospital Ambulance Transport CMN

Reason for Transfer: [ ] Service(s) not available at originating facility [ ] Patient / Family Request for Transfer [ ] Insurance Transfer
What service(s)? \_\_\_\_\_ Additional information: \_\_\_\_\_
Is this the closest facility capable of performing special service(s)? [ ] Yes [ ] No
If no, which facility is closest? \_\_\_\_\_
[ ] Physician Requests Level of Transport: [ ] BLS [ ] ALS [ ] CRITICAL CARE [ ] RN

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 certify that this patient requires ambulance transport based on the above information.

[ ] If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care services or assistance to the patient.

Signature of Physician or Healthcare Professional Print Name Date: \_\_\_\_\_
NPI No.: \_\_\_\_\_

If signed by a Healthcare Professional other than the attending physician, please indicate title of signer below.

- [ ] Physician Assistant [ ] Clinical Nurse Specialist [ ] Registered Nurse [ ] Nurse Practitioner [ ] Discharge Planner

# CERTIFICATE OF MEDICAL NECESSITY FOR REPETITIVE AMBULANCE TRANSPORT

*Only the Physician ordering the treatment requiring transport can complete a Certificate of Medical Necessity.*

**Repetitive Transport**—Three or more trips in a 10-day period or at least once a week for three consecutive weeks. Examples of necessity for repetitive transport may be dialysis, radiation, wound care, etc.

Initial Transport Date: \_\_\_\_\_ Expiration Date (*Maximum 60 days from date signed*): \_\_\_\_\_

When a patient's condition is such that an ambulance is required to safely transport the patient, the medical necessity of transport must be certified by the physician. Describe the condition of the patient requiring an ambulance transport (Examples: history of stroke with residual paralysis, inability to sit safely in a chair for longer than 20 minutes, amputation of lower extremity, etc.).

BE VERY SPECIFIC:

Date that client was last seen by the Physician certifying the ambulance transport: \_\_\_\_\_

Physician's Name (print): \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ NPI No.: \_\_\_\_\_ Date Certified: \_\_\_\_\_