



**KENOSHA**  
**262-553-3333**  
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:

**BED-CONFINED** (Patient unable to get up from bed without assistance, unable to ambulate, and unable to sit in chair or wheelchair.)

Reason: \_\_\_\_\_  
\_\_\_\_\_

This patient cannot be safely transported while strapped in a wheelchair that is bolted to the floor and unattended in the back of a moving wheelchair van.

Reason: \_\_\_\_\_  
\_\_\_\_\_

**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

Requires **TRAINED MONITORING** for:

Airway Control / Positioning or Suctioning

Continuous IV Therapy

Ventilator Dependent / Advanced Airway Monitoring

Cardiac Monitoring

Is medicated and requires monitoring

Detailed Explanation: \_\_\_\_\_  
\_\_\_\_\_

Requires **RESTRAINTS**

Physical—Type: \_\_\_\_\_

Chemical—Type: \_\_\_\_\_

Reason for Restraint: \_\_\_\_\_  
\_\_\_\_\_

**DECUBITUS ULCERS**: Size \_\_\_\_\_ Stage \_\_\_\_\_

Location:  Buttocks  Coccyx  Hip  Other: \_\_\_\_\_

Requires **OXYGEN** Enroute.

Is patient able to administer his or her own oxygen?  Yes  No

**ALTERED MENTAL STATUS**

Condition:  New Onset  Status Change

Patient exhibits:  Hostile  Agitated

Violent  Non-compliant

Is the altered mental status the result of sedation?  Yes  No

Type: \_\_\_\_\_

Exhibits a **DECREASED LEVEL OF CONSCIOUSNESS**

Unconscious  Stuporous (Semi-conscious)

Unresponsive  Intermittent Consciousness

Incoherent  Hallucinating

Lethargic  Head injury with altered mental status

**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. I understand that this information will be used by the Department of Health Services and the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

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. My signature below is made on behalf of the patient pursuant to 42 CFR 424.36 (b) (4). In accordance with 42 CFR 424.37, **the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:**

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: \_\_\_\_\_