WASHINGTON
262-820-1111
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:

☐ **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: ________________