(877)-985-5022

# CERTIFICATE OF MEDICAL NECESSITY

Patient Name______________________________________DOB___________________________

DATE___________________________Insurance_______________________________________

Sending Facility ________________________Receiving Facility ___________________________

Receiving Provider _____________________Sending Provider_____________________________

1. **This patient requires transfer to a different facility due to:**

- ☐ Patient requires a higher level of care which is: ___________________________________
- ☐ Patient requires service or therapy to treat their condition which is not available at the referring facility, Service or therapy is; ___________________________________________
- ☐ Other (please describe)_______________________________________________________

2. **There is a clinical benefit to the time saved by transporting by air: (Please check all that apply)**

- ☐ Long Distance: patient's condition requires rapid transport over a long distance
- ☐ Pick up point is not accessible by ground transportation
- ☐ Unstable patient with need to minimize out of hospital time
- ☐ Traffic patterns preclude ground transport at the time the transport is required
- ☐ Other (please describe) ______________________________________________________

______________________________________________________________________________

3. **Closest Facility:**

Medicare/Medicaid and Federal Employee insurance programs mandate air ambulance services to the closest appropriate facility able to provide needed services. If bypassing the closest facility, please state reason.

- ☐ No other closer facility exits
- ☐ Specialist: _______________is unable to accept patient due to__________________________
- ☐ Diversion: No beds/staffing
- ☐ No specialist available/particular service is not available at the time of transport
- ☐ Other (specify)____________________________________________________________

☐ Patient or Family request *

**Please note that Medicare/Medicaid & Federal Employee Program does not cover transport beyond the closest facility because the patient and/or family prefer a specific hospital or physician, or to maintain a continuity of care due to patient convenience unless there is medical justification or whether or not such an advantage exists.*

4. **If the closest facility is being bypassed, has the patient been advised that he or she may be responsible for additional mileage beyond the closest facility**?

Yes No N/A

5. Additional Information:

- ☐ Bed Bound
  - Unable to get up from bed without assistance, And
  - Unable to ambulate, And
  - Unable to sit in a chair or wheelchair
- ☐ Requires continuous oxygen, airway monitoring, or suctioning
- ☐ Is comatose and requires monitoring
- ☐ Has an unrepaired or recent fracture/joint replacement and is unable to bear weight and must remain immobile
- ☐ Is ventilator dependent
- ☐ Requires continues IV therapy
- ☐ Requires EKG cardiac monitoring
- ☐ Other___________________________
  ________________________________
  ________________________________

- ☐ Patient has severe contractures
  - Upper_____
  - Lower_____
  - Both______
- ☐ Requires Isolation precautions
  - VRE________
  - MRSA______
  - CDIFF______
  - Other_______
- ☐ Pain medication, given prior to transport, needs continuation of care and advanced life support monitoring
- ☐ Exhibiting signs of a decreased level of consciousness/awareness and/or is a danger to self or others:
- ☐ Confused
- ☐ Combative
- ☐ Lethargic
- ☐ Comatose

| I certify I have completed this report based upon the information available at the time of transport request. |
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______________________________________________________________________________

Refereeing Provider, Title (Print) Sign Date

To be filled out by clinician employed or contracted by the facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was being furnished.