



Medevac Alaska 24/7 Dispatch  
(877)985-5022  
907-538-1620  
251-348-7644

## CERTIFICATE OF MEDICAL NECESSITY

### SECTION 1 – GENERAL INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Transport Date: \_\_\_\_\_ This CMN is Valid for  Today or  Date Range: \_\_\_\_\_ to: \_\_\_\_\_ (no more than 60 days)  
Origin: \_\_\_\_\_ Destination: \_\_\_\_\_  
Is the patient's stay covered under Medicare Part A (PPS/DRG?):  YES  NO  
Closest Appropriate Facility?  YES  NO If NO, why is transport to a more distant facility required? \_\_\_\_\_

If hospital to hospital transfer, what services at destination that are required: \_\_\_\_\_  
If hospice pt, is this transport related to the pt's terminal illness?  YES  NO Describe: \_\_\_\_\_

### SECTION 2 – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. The following questions must be answered by the medical professional signing below for this form to be valid:

1) Describe the **MEDICAL CONDITION** (physical and/or mental) of this patient **AT THE TIME OF AMBULANCE TRANSPORT** that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition: \_\_\_\_\_

2) Is the patient "bed confined" as described in the following? To be "bed confined" the patient must satisfy all three of the following conditions:  
(1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.  
 YES.  NO

3) Can the patient be safely transported by car or wheelchair van? (i.e. seated during transport without a medical attendant)  
 YES.  NO

4) In addition to items 1-3 above, please check any of the following conditions that apply as supporting documentation. The supporting documentation must be maintained in the patient's medical records.

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Cardiac Monitoring Required  | <input type="checkbox"/> Danger to Self/Others  | <input type="checkbox"/> Patient is confused        | <input type="checkbox"/> Contractures |
| <input type="checkbox"/> Requires Continuous IV Therapy   | <input type="checkbox"/> Moderate/Severe Pain with Movement   | <input type="checkbox"/> Patient is comatose        |                                       |
| <input type="checkbox"/> Is Ventilator Dependent  | <input type="checkbox"/> Need/Potential Need for Restraints   | <input type="checkbox"/> Medical Attendant Required |                                       |
| <input type="checkbox"/> Special Isolation Precautions (i.e. Neutropenic, Contact, Airborne and/or Droplet) | <input type="checkbox"/> Non-Healed Fractures   |   |                                       |
| <input type="checkbox"/> Requires Oxygen & unable to self-administer  | <input type="checkbox"/> Orthopedic Device (Backboard, splint, pins, etc.) requiring special handling |   |                                       |
| <input type="checkbox"/> Hemodynamic Monitoring Required  | <input type="checkbox"/> Unable to sit in chair/wheelchair due to decubitus ulcers                    |   |                                       |
| <input type="checkbox"/> DVT lower extremity that req. Special Positioning                                  | <input type="checkbox"/> Morbid Obesity req. additional personnel to safely handle patient            |   |                                       |
| <input type="checkbox"/> Other (specify): _____   |   |   |                                       |

### SECTION 3 – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent 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

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name of Physician or Healthcare Professional

\_\_\_\_\_  
Credentials (MD, DO, PA, NP, RN, CNS)

*Form must be signed by patient's attending physician for repetitive transports (If 60 day option is checked above). For unscheduled transports, this form may be signed by a Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse or Discharge Planner if their attending physician is not immediately available.*