San Luis Valley RETAC Medical Necessity Form

Physician Certification Statement for Emergent Ground or Air Ambulance Transport

SECTION I – General Information

Patient's Name_____________________________________Date of Birth_____________Medicare # ___________

Transport Date___________________(PCS is valid for round trips on this date and for all repetitive trips in the 60 day range as noted below)

Is the patient's stay covered under Medicare Part A (PPS? DRG?) □ Yes □ No Is patient stable? _____________________

Service Transferring patient: (Check all that apply):

□ Alamosa □ Conejos County □ Baca/Crestone □ South Fork □ Costilla □ Mineral County □ Del Norte
□ Northern Saguache □ Monte Vista □ Center □ EAM □ FFL □ Reach □ CareFlight
□ Other ____

Transferring from: □ RGH □ SLVRMC □ CCH Transferring to: ____

Receiving ____ Physician: ____

If hospital – hospital transfer, describe services needed at 2nd facility not available at 1st facility.

□ Surgical □ Cardiology/Cath □ Ortho □ Intensive Care □ Psychological □ Other _____________________

☐ Patient transported to closest appropriate facility based on bed availability, specialty availability, continuity of care or sending providers judgement.

SECTION II- 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 medical professional signing must answer the following questions below for this form to be valid!**

1. Describe the MEDICAL CONDITION (physical or mental) of the patient AT THE TIME OF AMBULANCE TRANSPORT that requires patient to be transported in an ambulance and why transport by other means is contraindicated due to the patient's condition.
2. Is this pt. "bed confined" as defined below? □ Yes □ No

   To be "bed confined" the pt. must satisfy all three of the following conditions: (1) unable to get up from the bed without assistance: AND (2) unable to ambulate: AND (3) unable to sit in a chair or wheelchair
3. Can this pt. safely be transported by car or wheelchair van (without a medical attendant or monitoring)? □ Yes □ No
4. ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply.

			Requires oxygen – unable to self-administer
	Patient is comatose, confused		Hemodynamic/Cardiac monitoring required en route
	Danger to self or others		Special handling/isolation/infection control precautions required
	IV meds/fluids required		Unable to tolerate seated position for time needed to transport
	Medial attendant Required		Morbid obesity requires additional personnel/equipment to safely handle patient
	Need or possible need for restraints		Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
	Moderate/severe pain on movement		Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
	Other *(Please specify)*		

SECTION III – Signature of Physician or Healthcare Professional

I certify that the above information is true and correct based on my evaluation of this patient of the best of knowledge and professional training. I understand that this information will be used by Department of Health and Human Services, Health Care Financing Administration, and Centers for Medicare and Medicaid Services to support the determination of medical necessity for ambulance service.

Signature **of Physician or Healthcare Professional X**____**Date** ______________________

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, PA, CNS, NP, etc.)

____ **Phone #** _________________________

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SECTION IV – Patient Signature

The patient must sign here unless the patient is physical or mentally incapable of signing.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by (EMS Service) now, in the past or in the future until I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by (EMS Service), regardless of my insurance coverage and in some cases, may be responsible for any amount in addition to that which was paid by my insurance. I agree to immediately remit to (EMS Service) any payments that I receive directly from insurance or any source whatsoever for the services provided to me and assign all rights to such payments to (EMS Service). I authorize (EMS Service) to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medial information or other relevant documentation about me to release such information to (EMS Service) and its billing agents, the Centers for Medicare and Medicaid Services, any/or any other payors or insurers and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by (EMS Service) now, in the past or in the future.

X____ X____

Signature or Mark **Date** **Witness Signature** **Date**

Witness address: ____

SECTION V – Authorized Representative Signature

Note: if the patient is a minor, the patient or legal guardian should sign in this section.
Complete this section if the patient is physically or mentally incapable of signing.

Explain the circumstances that make it impractical for the patient to sign: ____
____

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid or any other payor for any services provided to the patient by (EMS Service) now or in the past, (or in the future where permitted). By signing below, I acknowledge that I am one of the authorized signers listed below. My signature is not an acceptance of financial responsibility for the services rendered.

Authorized representatives include only the following individuals:
( ) Patient's legal guardian
( ) Relative or other person who receives social security or other governmental benefits on behalf of the patient.
( ) Relative or other person who arranges for the patient's treatment or exercise other responsibility for the patient's affairs.
( ) Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e. ambulance services) but furnished other care, services or assistance to the patient.

X____

Representative Signature **Date** **Printed Name and Address of Representative**

SECTION VI - Ambulance Crew and Receiving Facility Signatures

Complete this section if: 1)The patient was physically or mentally incapable of signing and/or 2)No authorized representative (section V) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement: (Must be completed by crew member at any time during transport)

My signature below indicates that at the time of service, the patient named above was physically or mentally incapable of signing and that none of the authorized representatives listed in Section V of this form was available or willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Explain the circumstances that make it impractical for the patient to sign: ____

Name and Location of Receiving Facility: ____

Date and Time at Receiving Facility: ____

X____

Signature of Crewmember **Date** **Printed Name and Title of Crewmember**

Receiving Facility Signatures

B. Receiving Facility Representative Signature:

The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.

X____

Signature of Receiving Facility Representative **Date** **Printed Name and Title of Receiving Facility Representative**