Liberty Ambulance Service, Inc.

1626 Atlantic University Circle Jacksonville, Fl 32207 904-721-0008
Fax # 904-724-0226

Certificate of Medical Necessity

The physician responsible for determining medical necessity of non-emergency ambulance transport should complete this form. This form may also be completed and signed by an RN, PA, NP, CNS, or discharge planner who is employed by the hospital or facility where the patient is being treated, with knowledge of the patient's condition at the time of transport. for repeated transports, this form must be completed only by the physician, and must be re-validated every 60 days. We are required by Medicare law to present this form during audit for any nonemergency ambulance transport.

Patient Name _____ DOB_____

Medicare Part B benefits are payable for ambulance services only when the use of any other method of transport is medically contraindicated by the patient's condition. If the decision to use ambulance transport is based on the convenience of the patient, the patient's family, the patient's physician, or some other element of personal preference, Medicare coverage IS NOT available.

Please validate the patient's condition below:

Is the patient "bed confined" as defined below? ☐ Yes ☐ No

To be "bed confined" the patient must satisfy all three of the following condition: (1) unable to get up from bed without assistance; (2) unable to ambulate **AND** (3) unable to sit in a chair or wheelchair.

Can this patient safely be transported by care or wheelchair van? ☐ Yes ☐ No

Please check all that apply (in addition to answering questions above):

___ Contractures	___ Non-healed fractures	___ Patient Confused
___ Danger to Self/other	___ IV Meds required	___ Patient comatose.
___ Restrains required	___ Oxygen – unable to self admin	___ Patient Combative
___ Infection precautions	___ Cardiac monitoring required	___ Morbid Obesity

___ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds.

___ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc....) requiring special handling.

Other (specify) _____

_____

Date of transport: _____

Physician/Staff Signature – Credentials must be included: _____

Physician/Staff Printed Name: _____