# Medical Necessity Certification for Nonemergency Ambulance Transports

Request Date: _____/_____/_____ Transport Date: _____/_____/_____

Patient's Name: Medicaid Number:

Transported From: Transported To:

Physician's Printed Name:

In order for ambulance services to be covered, they must be medically necessary and reasonable. Medical necessity is established when the patient's condition is clinically considered severely disabled and as such that transportation by any other means (including services provided through the Medicaid Medical Transportation Program or through that which is included in the rate for Long Term Care - Nursing Facilities) is contraindicated. A round-trip transport from the client's home to a scheduled medical appointment (e.g., an outpatient or freestanding dialysis or radiation facility) is covered when the client meets the definition of severely disabled.

The HHSC Medicaid Program has defined "severely disabled" as that client's physical condition limits mobility and requires the client to be bed-confined at all times, unable to sit unassisted at all times, or requires continuous life-support systems (including oxygen or IV infusion).

Please complete the questions below in order for the authorization to be evaluated under Medicaid coverage criteria.

1.)Is the patient severely disabled as defined by the above definition? ❑Yes ❑No
2.)If no, this client does not qualify for nonemergency ambulance transport.
3.)If yes, please check the appropriate medical condition listed below.

**This patient:**

- ❑ Requires continuous oxygen and monitoring by trained staff
- ❑ Requires airway monitoring or suction
- ❑ Requires restraints or sedation **(MUST BE EXPLAINED IN OTHER)**
- ❑ Comatose and requires trained monitoring
- ❑ Is actively seizure-prone and requires trained monitoring
- ❑ Had to remain immobile because of a fracture/possibility of a fracture that had not been set
- ❑ Patient is ventilator-dependent
- ❑ Contractures **(MUST BE EXPLAINED IN OTHER)**
- ❑ Has advanced decubitus ulcers and requires wound precautions **(MUST BE EXPLAINED IN OTHER)**
- ❑ Requires isolation precautions (VRE, MRSA, etc.) **(MUST BE EXPLAINED IN OTHER)**
- ❑ Patient requires continuous IV therapy
- ❑ Requires cardiac monitoring
- ❑ Is exhibiting signs of a decreased level of consciousness **(MUST BE EXPLAINED IN OTHER)**
- ❑ Total hip replacement requires hip precautions and cannot sit safely **(MUST BE EXPLAINED IN OTHER)**
- ❑ **Other** (explain)

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FOR A NONEMERGENCY AMBULANCE TRANSPORT FROM THE MEDICAID PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, ARE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND STATE LAWS. * **THIS AUTHORIZATION WILL BE VALID FOR 60 DAYS FROM THE DATE OF ISSUANCE AND WILL CERTIFY THAT THE PATIENT REMAINS SEVERELY DISABLED FOR THAT PERIOD OF TIME.**

_____
Print name and title

Signature of MD, RN, PA or Social Worker

_____/_____/_____
Date Signed

**EMS STAFF USE ONLY**

Contacted_____(Name of person you spoke with) at _____(Facility Name) on_____(Date) at _____(time) and confirmed that_____(Person who signed name and title) is the person who signed this report.

_____
Printed Name of EMS Staff

_____
Signature of EMS Staff

Please return the completed form to:
Scott & White - EMS
505 N. 3rd St.
Temple, TX 76501

Attn: EMS Billing Coordinator
Or: Fax to my attention @ 254-774-1718
I appreciate your assistance. Should you require additional information please do not hesitate to contact me at (254) 774-1717

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