

Certificate of Medical Necessity
Non-Emergency Ambulance Transportation Form
LifeCare Medical Transports

Please complete this form for each scheduled ambulance transport. Please document why the patient must travel by ambulance as opposed to any other means of transportation. *This form is required by HCFA to process the patient's claim with Medicare.*

Patient Name: _____

Patient's Medicare #: _____ **Date of Transport:** _____

Ambulance transportation (is) _____ (is not) _____ medically necessary.

Ambulance Transportation is medically necessary for the following reasons: (select one)

- _____ 1. **Bedridden.** For Medicare purposes, this means "bed confined" or "bed imprisoned." It does not mean that the patient needs assistance into the ambulance or stays in bed most of the time. It further means "before" and "after" the ambulance trip. It would not include a person who became ill and was placed on bed rest by their physician. Patients may be considered bedridden when they cannot get out of bed on their own volition. There should also be no history of trips outside of the bed by means other than ambulance since becoming bed confined.

- _____ 2. **Other means of transportation are contraindicated because it would be harmful to the patient's condition.** Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. Specific medical documentation must accompany these claims.

List the condition(s) (*not diagnosis*) which requires this patient to travel by ambulance:

- 1. _____
- 2. _____
- 3. _____

Signature of physician* _____ Date _____

*(If physician is not available, a RN or discharge planner may sign the form, and have the form later counter-signed by the physician.)

Instructions: Please give this form to the ambulance crew upon discharge. Otherwise, it may be faxed to our billing department at 540-752-5194.

LifeCare Medical Transports
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1170 International Parkway
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