Alliance Mobile Health

Physician's Certification for Medical Necessity of Ambulance Service

Section I - General Information

Transport Date	Certification Expiration Date - max 60 days: _____/_____/_____
Patient Name:	
Transport To (facility name and address):	
Transport From:	
Contact Phone Number @ Destination:	

Dispatch: 1-888-843-3772

For any billing questions, call:
248-457-0344 ext. 223 or 224
Fax 248-457-0376
Email: billing@alliancemobilehealth.org

Section II - Medical Necessity Questionnaire

Please check the appropriate medical condition(s) below, which would necessitate transport by ambulance according to HCFA definition, and make all other means of transportation contraindicated based on patient health and safety. *(HCFA definition of confinement is: unable to get from bed without assistance; ambulate; and sit in a chair, including a wheelchair; does your patient meet any of these criteria's?)*

- ❑ Is comatose and requires trained monitoring.
- ❑ Requires oxygen and no portable oxygen is available.
- ❑ Requires physical restraints and/or the patient is chemically restrained
- ❑ Is bed confined at the time of transport (reason:_____).
- ❑ Exhibits signs of decreased level of consciousness.
- ❑ Is seizure prone requiring trained monitoring.
- ❑ Is suffering from decubitus ulcers and requires wound precautions.
- ❑ Requires airway monitoring and/or trained suctioning.
- ❑ Requires cardiac ECG monitoring.
- ❑ Moved from a small rural hospital to a larger, better equipped hospital.
- ❑ The patient must be moved from a psychiatric to a medical hospital.
- ❑ The patient must be moved to a psychiatric ward.
- ❑ Special diagnostic studies are needed.
- ❑ Is able to tolerate a wheelchair but is inadvisable due to other conditions.
- ❑ Contractures
- ❑ IV meds/fluids required
- ❑ Patient Combative
- ❑ Need or possible need for restraints
- ❑ Special handling/isolation/infection control precautions required
- ❑ Other reason:_____

Precautions/Isolation Necessary: ❑ Universal ❑ Respiratory ❑ AFB

Is this patient "bed confined" as defined below? ❑ Yes ❑ No
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.

Can this patient safely be transported by car or wheelchair van (i.e. seated during transport, without a medical attendant or monitoring?)
❑ Yes ❑ No

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, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services, Health Care Financing Administration, on/or its agents, to support the determination of medical necessity for ambulance services.

Physician Printed Name: _____

Authorized Signature: _____ Date Signed: _____

❑ Physician ❑ Case Mgr. ❑ PA ❑ NP ❑ RN

Who can Sign? Government regulations require that this form may only be signed by

- Medicare patient - As a Primary Physician, PA, NP, RN, Case Manager or Discharge Planner
- **Medicaid patient - As a Primary Only a Physician, PA or NP may sign.**
- Dialysis patient - **Only a Physician may sign.**

LPN's are not authorized to sign for any transfer due to federal regulations.

Blue Cross Blue Shield and the following Medicaid Providers require a Physician, Physician Assistant or Nurse Practitioner on PCS (ambulance authorization for medical necessity) forms:

Bluecaid of MI
CareSource - MI
United Health Care (UHC)
Health Plan of MI
Healthplus Partners
Mclaren Health Plan
Midwest Health Plan
Molina Healthcare of MI
Omnicare Health Plan
Physician's Health Plan of MI
Procare Health Plan
Total Health Care
Upper Peninsula Health Plan
Blue Cross Blue Shield

White Copy: Alliance • Yellow Copy: Chart