

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name	Origin of Services
Medicaid ID	Destination Name
Date of Transport	Destination Address

Standard: Fax to 1-866-768-9374 (If urgent, call 1-866-595-8133)

SECTION I (To be completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below (check one):

<input type="checkbox"/>	Emergency Ambulance: Patient's medical condition requires immediate transport and requires medical treatment in route. Describe the medical condition of the patient which requires this type of transport:
<input type="checkbox"/>	Non-Emergency Ambulance: The patient is bed-confined, i.e. unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair, and requires stretcher transport, either scheduled or unscheduled, or the patient may require some simple medical care in route, but is stable and is not likely to require the attendance of an EMT. Describe the medical condition of the patient which requires this type of transport:
<input type="checkbox"/>	Non-Emergency Ambulance (recurring): The patient will require transportation _____ times a week to receive: <input type="checkbox"/> Dialysis <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Physical therapy <input type="checkbox"/> Other _____ for a period of _____ months
<input type="checkbox"/>	Non-Emergency, Non-Ambulance: Patient is stable, not expected to require any medical attention in route, is ambulatory or wheelchair bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason (check one):

<input type="checkbox"/>	Nearest Facility
<input type="checkbox"/>	Preference of Primary Care Physician
<input type="checkbox"/>	The patient requires specialized services not available at closer facility. SERVICE: _____
<input type="checkbox"/>	Other:

SECTION II (To be completed by Treating MD/PA/NP/CNS/RN/DON)

Signing this certification indicates that, in your professional judgment, transportation of the above name patient was necessary based on the patient's condition and in accordance with the statements in Section 1 above. Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws

I have read the above certification and I:	
<input type="checkbox"/>	Agree with the determination
<input type="checkbox"/>	Disagree with the determination for the following reason:

Signature: _____ **Print:** _____ **Date:** _____

Authorization Number*			
Medic 1	Name	EMT #:	Date:
Medic 2	Name	EMT #:	Date:

Provide the authorization number to the ambulance service providing the transport.