

RAPID RESPONSE

A Team for Life!



Dispatch Center: (877) 797-9900

Local: (313) 817-6000

Physician's Certificate of Medical Necessity

Ambulance Transportation Form

For all non-emergent ambulance transports:

Insurance carriers require a physician's summary and signature certifying that this patient fulfills the medical necessity requirements for stretcher transportation by ambulance. This patient cannot be transported by wheelchair van, taxi cab, or any other means because it would endanger the patient's health.

Date: _____

Patient Printed Name: _____

Transferring Facility: _____

Receiving Facility: _____

For hospital to hospital transfers please indicate the services transferring facility cannot provide:

If services can be provided at the initial hospital, transportation to another hospital is usually not covered by insurance.

- | | |
|---|--|
| <input type="checkbox"/> Burn unit required | <input type="checkbox"/> Specialized diagnostics or surgery (describe) |
| <input type="checkbox"/> Inpatient psychiatric services | <input type="checkbox"/> Specialized pediatric services (describe) |

Please check all that apply to the patient's condition:

- Unable to sit in a wheelchair for periods greater than 15 minutes
- Unable to stand and pivot without assistance
- Severely decreased level of consciousness
- Oxygen administration or portable ventilator
- Monitoring of prescribed I.V. medication(s) by portable I.V. pumps (ALS service only)
- Cardiac monitoring ECG
- Airway monitoring and suctioning
- Physical restraining (leather, soft or Posey restraint and/or sedation) Required to prevent elopement, and or injury to patient or others.
- Bedridden due to atrophy or paralysis
- Debilitated Post-Op recovery
- Bedridden due to fracture, post fracture, or unset fracture.
- Chemical sedation requiring monitoring
- ALS for precautions (Describe below)
- Wound precautions (Decubitis Ulcer or Bed sore)
- Maintenance of IV fluids or port

Supporting Diagnosis: _____

Narrative: _____

Physician Signature: _____

Physician Printed name: _____

Medical Billing Office: (313) 817-0080

Fax: (313) 817-0077

Additional copies of this form may be obtained from our website at:

WWW.RREMS.COM