MEDIC
Mecklenburg EMS Agency

REQUIRED - FAX COMPLETED FORM TO 704.943.6192

STOP - **If this patient has Medicaid Managed Care, please contact the appropriate transport broker to schedule a transport.**

WellCare: One Call 877-598-7602 ■ United Healthcare: ModivCare 855-397-3604 ■ Health Blue: ModivCare 855-397-3602
■ AmeriHealth Caritas: Member Services 855-375-8811 ■ Carolina Complete: ModivCare 855-397-3601 ■

TRANSPORTATION INFO

Pick Up Date: _____ P/U Facility Name: _____ P/U Facility Phone: _____

Requested P/U Time: _____ P/U Address: _____ P/U Room #: _____

Appt Time: _____ _____

Promised Time: _____ Dest. Name: _____ Dest. Phone: _____

Person Req'ing: _____ Dest. Address: _____ Dest. Room #: _____

Preferred Phone: _____ _____

PATIENT INFORMATION (OR STICKER)

Patient Name: _____ Diagnosis: _____

Patient DOB: _____ What is the medical reason for the transport? _____

Patient SSN: _____ _____

What is the reason why an ambulance is required? _____

Why would transport (by any other means) be harmful to the patient? _____

_____

C/S/Z: _____ MD/DO NAME: _____

PATIENT CLINICAL INFO AND SPECIAL CONSIDERATIONS

Special Equipment Needs: IV ☐ Cardiac Monitor ☐ Oxygen ☐ Vent/Trach ☐

Weight = _____ Is the patient in a bariatric bed in your facility? Yes ☐ No ☐

Will patient need lifting assistance? Yes ☐ No ☐ Other Considerations: _____

VITAL SIGNS

B/P: _____/_____ HR: _____ Resp: _____ Temp: _____ Blood Sugar: _____

IV Medications: Yes ☐ No ☐ If "Yes" please describe: _____

Communicable Disease(s): Yes ☐ No ☐ If "Yes" please describe: _____

BILLING INFORMATION

Is this a round trip transport to/from the originating facility? Yes ☐ No ☐ If "Yes": A form is required for EACH transport

If "Yes": Is the Service not available at original facility? Yes ☐ No ☐ Describe service needed: _____

The facility will be billed for this transport Hospital Account # _____ DEPT: _____

Is the patient from a skilled nursing facility? Yes ☐ No ☐

If "Yes", is the patient in the "Part A" period (1st, 100 days of stay) Yes ☐ No ☐

If "Yes", what service is the transported patient to receive? _____

The facility will be billed for this transport SNF Account # _____ DEPT: _____

If "No":

Is the patient an In-Patient at the hospital? Yes ☐ No ☐ If "Yes", are they discharged from the hospital? Yes ☐ No ☐

Why is the patient being transported to another facility? _____

Is the receiving facility the closest appropriate facility available to provide the care needed for the patient? Yes ☐ No ☐

Form revised: 07/01/2021

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CERTIFICATION STATEMENT (PCS OR NPCS)

A CERTIFICATION STATEMENT is required for all transports. Is the PCS attached? **Yes** ☐ **No** ☐

INSURANCE

Medicaid#:_____ Medicare#:_____ Insurance Co/Resp. Party:_____ Insurance Co. Auth#_____

Date Obtained:_____ Mailing Address:_____

Policy / P.O. #_____ Insurance Co/Resp. Party Phone #_____

REQUIRED-Is the destination facility the closest for service? **Yes** ☐ **No** ☐

If "Yes", please explain why this facility is the closest appropriate:_____

_____

If no, who from your facility will be financially responsible for authorizing this transport, if denied by insurance.

Name:_____ Department:_____ Phone #_____

I certify that the information provided in this form is complete, accurate and supported in the aforementioned patient's medical records -to the best of my knowledge. The information being utilized on this form is being gathered to assist in seeking reimbursement from third party payers or the Medicare Program.

Signature:_____ Name (printed):_____ Date:_____

A Certification Statement is required for all Medicare patients being transferred or discharged from a hospital, skilled nursing facility, or transported from a skilled nursing facility for an outpatient visit to a physician's office, outpatient clinic, or other medical facility if the appointment is scheduled non-emergency, or non-scheduled non-emergency.

Patient's Name:_____ Sex: Male ☐ Female ☐ Date of Birth:_____

CERTIFICATION STATEMENT

In order to meet medical necessity the patient must meet one or more of the following four criteria.
Transportation by ambulance is needed for this patient for the following reasons:

1.Bed confined at the time of transport
(Complete question 4N, if all conditions apply below):

☐ Unable to ambulate, unable to get up without assistance and unable to sit in a chair or wheelchair.

2. ALS monitoring required
(Check applicable condition):

☐ Cardiac/hemodynamic
☐ Advanced Airway Management
☐ IV meds required
☐ Chemical Restraint

3. Monitoring is required:

☐ Suction
☐ Airway control/positioning
☐ Third Party Assistance

4. Medical Conditions that contraindicate transport by other means:
(Check applicable conditions):

☐ a. Patient Safety-danger to self or others
☐ b. Needs Medical Observation
☐ c. Communicable disease
☐ d. Contractures
☐ e. Hazardous material exposure
☐ f. Morbid obesity
☐ g. Special handling to avoid further injury. Explain:
☐ h. Unable to be transported in seated position due to **decubitus ulcers stage** sacrum and stage _____ of buttock, coccyx, hip
☐ i. Positioning in wheelchair or standard car seat inappropriate due to contracture or recent extremity fractures
☐ j. Paralysis Hemi: ☐ Para: ☐ Quad ☐
☐ k. Fracture of the:_____
☐ l. Unsafe to be transported in seated position due to:_____
☐ m. Other pertinent medical conditions:_____
☐ n. If patient is unable to ambulate, walk or sit without assistance, please explain why?_____

_____

*****Only a Physician can sign for Repetitive Patients.** Repetitive Patient is defined as transported for same condition once a week for 3 consecutive weeks or 3 times in a 10 day period.

I certify that our institution has furnished care or other services to the above named patient.

Non-Physician's Signature_____ **Date:**_____

Non-Physician's Name (please print or type)_____

*****Physician's Signature:**_____ **Date:**_____

*****Physician's Name (please print or type)**_____

Please check the appropriate box for above signature: MD ☐ NP ☐ PA ☐ RN ☐ LPN ☐ Discharge Planner ☐
Social Worker ☐ Case Manager ☐ Clinical Nurse Specialist ☐