Ambulance Transfer

MyMichigan Health EMS

Transport Date: ______________________

Patient's Name: ______________________ Medicare #: ______________________

Transported From: ______________________ Transported To: ______________________

Physician's Printed Name: ______________________ License # or UPIN: ______________________

In order for Ambulance Services to be covered, they must be medically necessary and reasonable. Medical necessity is established when **the patient's condition is such that transportation by any other means is contraindicated.** Please complete the questions below in order for the ambulance claim to be evaluated under Medicare coverage criteria.

1) Is the patient able to be safely transported by any means other than ambulance?
   ☐ Yes ☐ No If **No,** Please continue

The Health Care Financing Administration has defined **"bed confinement"** as **(all three criteria must be met):**

The patient is:

- Unable to get up from bed without assistance; **and**
- Unable to ambulate; **and**
- Unable to sit in a chair or wheelchair

2) Is the patient bed-confined as defined above? ☐ Yes ☐ No
3) If **No**, please check the **appropriate medical condition listed below.**

This patient:

☐ Required restraints to prevent harm and/or injury to self or others **(explain)**
☐ Requires isolation precautions **(explain)**
☐ Requires cardiac monitoring
☐ Has decubitus ulcers and requires wound precautions **(explain)**
☐ Requires continuous oxygen monitoring by trained staff
☐ Had to remain immobile because of a fracture that had not been set or the possibility of a fracture
☐ Contractures
☐ Is ventilator dependent
☐ Is exhibiting signs of a decreased level of consciousness **(explain)**
☐ Requires continuous IV therapy

Note: patients who are generally mobile with portable oxygen would not require non-emergency ambulance transportation based solely on the need for oxygen.

☐ Other, please specify, or **(explain):** ______________________

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I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical records of the patient.

Signature of Ordering Physician or Authorized Person ______________________ Date Signed ______________________