Bangs Ambulance, Inc. - Medical Necessity Certification Statement

Please fax to: 607-277-9281 Mon-Fri 7:30 am to 3:30 pm
607-272-5438 all other times

Dispatcher 607-273-1161

HOSPITAL TO HOSPITAL

Medicare & many insurances will only cover transport cost to the closest facility able to perform the needed procedure or treatment.

Section One – Beneficiary Information

Name _____ Date of Transport _____ Level ☐ Emergent ☐ Urgent ☐ Scheduled

List current & related diagnosis:_____

Section Two - Transport Information

From _____ To _____ Round Trip ☐ Yes ☐ No
sending facility receiving facility

1) What is the service or treatment needed (be as detailed as possible) _____

_____

_____

2) Is the needed procedure or treatment available at the sending facility? ☐ Yes *(insurance will not cover the cost of transfer)* ☐ No

3) What is the closest facility that can typically provide this treatment? _____
Check if applicable: ☐ This facility is on Diversion ☐ No Bed/Provider / Procedure currently Available

4) Is the receiving facility the closest facility? ☐ Yes, closest facility *(go to question 6)*
☐ No, patient's preference *(insurance may not cover additional mileage)*
☐ No, physician's preference *(insurance may not cover additional mileage)*

5) Were closer facilities contacted? ☐ Yes *(indicate responses below)* ☐ No *(indicate reason not contacted below)*

Hospital Name(s) & Responses: _____

_____

6) Check all that apply at the time of transport

- ☐ patient requires cardiac monitoring
- ☐ patient require hemodynamic monitoring
- ☐ patient is sedated needs monitoring
- ☐ patient needs or may need restraints(physical/chemical)
- ☐ patient is danger to self or others
- ☐ patient is confused or lethargic
- ☐ patient is unaware of person / place / event
- ☐ patient has active infectious disease
- ☐ patient is on oxygen now and may need oxygen during transport

Section Three – Ordering Provider Information

_____ _____
Signature of Physician or Authorized Healthcare Professional Date

_____
Print name and credentials of physician or authorized healthcare professional (MD, DO, RN, etc)

Title of person signing above:

- ☐ Physician (preferred)
- ☐ Family Nurse Practitioner
- ☐ Registered Nurse
- ☐ Clinical Nurse Specialist
- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ LPN
- ☐ Social Worker
- ☐ Case Manager
- ☐ Discharge Planner

_____
NPI of ordering provider

December 2021