# 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

## ALL TRANSPORTS EXCEPT HOSPITAL TO HOSPITAL

Name _____ Date of Transport _____

List current & related diagnosis:_____

## Section Two Transport Information

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

1) The patient must be transported by ambulance – all other means of transportation are contraindicated. Explain why this is true.
   a) Medical Condition of Patient: _____
   b) Physical Condition of Patient: _____
2) Mark all that apply:
   a) Patient's present condition
      ☐ The patient is bed confined. Reasons for bed confinement: _____
      ☐ The patient cannot get out of bed without assistance.
      ☐ The patient cannot sit in a wheel chair safely for length of transport
      ☐ The patient does not need an ambulance and can go by other means. The patient will be responsible for cost.
   b) Patient has infectious disease ☐ yes ☐ no
      What is the disease:_____body affected area: _____
      ☐ The disease is active now
      ☐ The disease is inactive now
      ☐ The active status is not known but there is no evidence to show it is inactive now.
   c) Patient needs oxygen ☐ yes ☐ no
      Reason the patient is on oxygen:_____
      ☐ The patient is on oxygen now and needs oxygen during the transport.
      ☐ The patient can regulate and administer their own oxygen
      ☐ The patient cannot regulate or administer their own oxygen and is explained in 1a or 1b above.
      ☐ The patient is a new oxygen patient and is on it for the first time.
3) Closest Facility
   ☐ The patient is being transported to their residence.
   ☐ This is not the closest facility able to treat the patient. The patient will be responsible for the cost of miles beyond the Closest facility. Most likely the closest facility is: _____
   ☐ Closer facilities were contacted and they did not have beds or would not accept the patient.
   What facilities were contacted: _____
   ☐ This is the closest facility able to care for the patient. Explain why: _____
   _____
4) Check all that apply at the time of transport – must be explained in 1a or 1b above.
   ☐ has moderate/severe pain on movement – where: _____
   ☐ has non healed fracture – where: _____
   ☐ is unaware of person / place / time (circle)
   ☐ is combative to self or others
   ☐ has or may need restraints (physical or chemical)
   ☐ is lethargic or confused
   ☐ is morbidly obese – requires additional personnel – weight: _____

## Section Three Ordering Provider Information

_____ _____ _____
Printed name of physician or FNP care is provided under Signature Date

Above Physician or FNP NPI# _____

_____
Printed name of above signature

Title of person signing above:
☐ Physician (preferred) ☐ Physician Assistant ☐ Nurse Practitioner ☐ Discharge Planner
☐ Family Nurse Practitioner ☐ Registered Nurse ☐ Clinical Nurse Specialist
☐ LPN ☐ Social Worker ☐ Case Worker