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

URGENT CARE TO HOSPITAL

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

Name		Date of Transport	
List current & related diagnosis:			
Section Two Transport Information			
Fromsending facility	_To	eceiving facility	[] Yes Round Trip [] No
What is the service or treatment needed (be a	is detailed as possik	ble)	
If these services can be performed here, then insurar	nce will not cover the	cost of transfer.	
[] The treatment that is needed by the patransported by ambulance to the Emergency			
[] The treatment that is needed by the parameter to the Emergency Department. The parameter responsible for the cost of transport. 3) [] The patient cannot be discharged due to the	tient or physician is re	equesting transport by ambula	ance as the patient will be
4) 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/chemostraints)	[] patient [] patient [] patient	is danger to self or others is confused or lethargic is unaware of person / place / o has active infectious disease is on oxygen now and may nee	
Section Three Ordering Provider Informati	on		
Printed name of physician or FNP care is provided under Above Physician or FNP NPI#	Signature		Date
	Printed name of person signing above:[of above signature] Physician (preferred)] Family Nurse Practitioner	
January 2020]]]]]	Registered Nurse Clinical Nurse Specialist Physician Assistant Nurse Practitioner Discharge Planner	[] Social Worker [] Case Manager