# CERTIFICATION OF AMBULANCE TRANSPORTATION

| | |
|---|---|
| Recipient Name | Origin of Services |
| Medicaid ID | Destination Name |
| Date of Transport | Destination Address |

☐ **Standard:** Fax to 1-888-590-4183 (If urgent, call 1-866-595-8133)

## SECTION I (To be completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below (check one):

| | |
|---|---|
| ☐ | **Emergency Ambulance:** Patient's medical condition requires immediate transport and requires medical treatment in route. **Describe the medical condition of the patient which requires this type of transport:** |
| ☐ | **Non-Emergency Ambulance:** The patient is bed-confined, i.e. unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair, and requires stretcher transport, either scheduled or unscheduled, or the patient may require some simple medical care in route, but is stable and is not likely to require the attendance of an EMT. **Describe the medical condition of the patient which requires this type of transport:** |
| ☐ | **Non-Emergency Ambulance (recurring):** The patient will require transportation _____ times a week to receive:<br>☐ Dialysis ☐ Radiation therapy ☐ Physical therapy ☐ Other _____<br>for a period of _____ months |
| ☐ | **Non-Emergency, Non-Ambulance:** Patient is stable, not expected to require any medical attention in route, is ambulatory or wheelchair bound, and can be transported in an automobile or van. |

Patient transported to the above named facility for the following reason (check one):

| | |
|---|---|
| ☐ | Nearest Facility |
| ☐ | Preference of Primary Care Physician |
| ☐ | The patient requires specialized services not available at closer facility. **SERVICE:**_____ |
| ☐ | Other: |

## SECTION II (To be completed by Treating MD/PA/NP/CNS/RN/DON)

Signing this certification indicates that, in your professional judgment, transportation of the above name patient was necessary based on the patient's condition and in accordance with the statements in Section 1 above. Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws

| I have read the above certification and I: | |
|---|---|
| ☐ | **Agree** with the determination |
| ☐ | **Disagree** with the determination for the following reason: |

**Signature:** _____ **Print:** _____ **Date:** _____

| **Authorization Number*** | | | |
|---|---|---|---|
| **Medic 1** | **Name** | **EMT #:** | **Date:** |
| **Medic 2** | **Name** | **EMT #:** | **Date:** |

*Provide the authorization number to the ambulance service providing the transport.