GALLOWAY TOWNSHIP AMBULANCE SQUAD

P.O. Box 784
Pomona, NJ 08240

Physician's Medical Necessity Certification

Complete 1 (one) form for every scheduled/unscheduled non-emergency ambulance transport.
(This applies to repetive and/or one-time transports)

Patient's Name: **Date of Birth:**

Social Security #: **Health Insurance Claim # (HIC):**

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

The Health Care Financing Administration has defined "Bed Confinement" as the following:

The patient is:

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

1. Is the patient bed confined as defined by the above definition? Yes No
2. If no, please check the appropriate medical conditions listed below:

This patient:

requires restraint to prevent harm and/or injury to self or others (provide explination below in other).
had to remain immobile because of a fracture that had not been set or the possibility of a fracture (i.e. hip fracture).
requires cardiac monitoring.
is ventilator dependant.
requires continuous IV therapy.
requires continuous oxygen monitoring by trained staff (Note: Patient's who are generally mobile with portable oxygen would not require non-emergeny ambulance transportation based solely on the need for oxygen).
requires other services (please specify):

I certify that the information contained herin is, to the best of my knowledge, complete and accurate and supported in the medical record of the patient. The information being utilized on this form is being gathered to assist in seeking reimbursement from third party payers such as the Medicare program. I understand that any intentional misrepresentation or falsification of essential information, which leads to inappropriate payments, may be subject to investigations under applicable Federal and/or State laws.

Physician's Name: **UPIN (9 Digits):**
Physician's Address:
Physician's Phone #: **Extension:**

Physician's Signature: ____________________________________ **Today's Date:**

Physician Certification is good 60 days from date of physician's signature.