Coastal Ambulance -Supplemental to the PCS Form- Medical Necessity Questionnaire Form
Fax to Dispatch Office at 321-633-8501 Est.1/2012

Medicare considers Ambulance Transportation as **medically necessary** when other means of transport would be potentially harmful to the patient and as a result endanger the patient's health. Medical Necessity is determined based on the condition of the patient **at the time of service.** *If the patient could be transported safely by other means such as wheelchair van, non-medical stretcher or car then medical necessity does not exist.* Coastal always remains available to provide ambulance transport as needed. However, we will only be able to bill Medicare and other reimbursement carriers for services that meet medical necessity criteria. If you have any questions please contact our Billing Staff for advice at 632-5092.

Patient Name: _____ Transport/Certification Date: _____

Medical Necessity Questionnaire - Describe the **medical condition** (mental and/or physical) of this patient **at the time** of transport that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition: **(Check all that Apply)**

Note: Supporting documentation for any boxes checked must be documented in the patient's medical records.

Medical Issues:

__ Requires oxygen & monitoring by trained staff, unable to self-administer, regulate or adjust.
Medical Condition requiring Oxygen: _____
__ Decreased Level of Consciousness such that the patient could not make emergency needs known.
__ Exhibiting signs and symptoms of acute respiratory or cardiac distress posing a patient risk.
__ Medicated or Sedated at time of transport requiring trained monitoring.
__ Seizure prone requiring trained monitoring.
__ Decubtitis (stage III or IV) or Stasis Ulcers. Location _____
__ Must remain immobile due to unset fracture or possibility of fracture.
__ Recent CVA (____/____/____) Date of CVA ___Possible CVA ___Residual CVA affecting patient today.
__ Moderate/Severe pain: Location of Pain_____ Level on scale of 1-10 ___ (10 = highest)
__ Altered Mental Status/Confusion
__ Pregnancy Complications.
__ Requires chemical/physical restraints and continuous trained monitoring.
__ May exhibit aggressive behavior without warning.

Physical Issues:

__Patient is unable to safely transfer, move themselves to a wheelchair or is at risk of falling from the wheelchair while in motion.
__Recent hip or leg fracture. ___With orthopedic device ___ Without orthopedic device
__Muscle atrophy, making sitting up a hazard.
__Hemiplegia ___Paraplegia ___Quadriplegia
__Poor trunk control. Cannot remain upright. Falling over may pose a threat to the health of the patient.
__Diminished upper body strength or muscle atrophy would place the patient at risk in wheelchair.
__Body Rigidity ___Flexion Precautions
__Recent lower limb amputee (____/_____/____) date of amputation
__Contractures ___ Upper ___Lower ___Left ___Right
__Bariatric patient affecting safety in wheelchair or stretcher.
__Excessive weight of patient would place the patient's health, organs or limbs in jeopardy during transport.

Other criteria that may support medical necessity:

_____
_____
_____

Certification Signature: I certify that all the information provided on this form regarding this patient is accurate at the time of the transport.

Signature: _____ Printed Name (legible): _____ Date: _____

Title (Check One) ___Attending Physician ___Registered Nurse ___Discharge Planner

___Clinical Nurse Specialist ___Physician's Assistant ___Certified Nurse Practitioner