Mile High Ambulance, LLC
8451 Brighton Rd
Commerce City, CO 80022
MileHighAmbulance.com

Denver Metro: (303) 564-6636
Fax: (720) 398-3477
Email: appointments@milehighambulance.com

Ambulance Transfer Form

Medical Necessity Certification Statement

Initial Transport Date: ______________________________ Is this a repetitive transport? (Max. 60 days): **Yes / No** (Circle One)

Patient Name: ____ DOB: ___________________________________

Supporting Diagnosis: ____

Transport From: ____ Transport To: ____

Attending Physician: ____

Bed Confined? **YES / NO** (Circle One) CMS Definition: *Inability to get up from bed without assistance, ambulate, and sit in a chair, including a wheelchair (must meet all criteria).*

PLEASE CHECK ALL THAT APPLY:

- ❏ Requires continuous oxygen & monitoring by trained staff
- ❏ Requires airway monitoring or suctioning
- ❏ Requires cardiac monitoring or IV maintenance
- ❏ Comatose and requires trained monitoring
- ❏ Is seizure prone and requires trained monitoring
- ❏ Is exhibiting signs of decreased level of consciousness
- ❏ Requires restraints
- ❏ Contractures: lower_______ upper _______ both______
- ❏ Fracture of the:________________________________
- ❏ Has decubitus ulcers & requires wound precautions
  - ❏ **Define (stage & location):** _______________________________________
- ❏ Requires isolation precautions (VRE, MRSA, etc.)
- ❏ Patient is ventilator dependent
- ❏ Paralysis (hemi, semi, quad)
- ❏ Dementia, Alzheimer's, AMS
- ❏ Requires psychiatric care

Other reason: ____

If hospital transfer, describe below services needed at 2nd facility not available at 1st facility:

____

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by a medically trained personnel is required. I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge. I understand that this information will be used by the Centers for Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services. (Note: An LPN is not authorized by Medicare to sign this form unless they are a Discharge Planner).

- ❏ Physician
- ❏ Physician Assistant
- ❏ Nurse Practitioner
- ❏ Registered Nurse
- ❏ Certified Nurse Specialist
- ❏ Discharge Planner
- ❏ Licensed Practical Nurse (LPN)
- ❏ Social Worker
- ❏ Case Manager

Print Name: ____

Sign Name: ____

Date Signed: ___________/_____________/________________

[Place Patient Sticker here]