

Medical Necessity Form
Non-Emergency Ambulance Transportation: GROUND

DEMOGRAPHIC INFORMATION:

Patient Name:	Patient DOB:	Date of Request/Transport:
	Patient ID#:	
Requesting Provider:	Ordering Physician:	
Ambulance Provider Fax #:	Ambulance Provider Name:	Ambulance Provider ID#:
Transport From:	Transport To:	Purpose of Transport:

Tufts Health Plan may cover non-emergency, basic or advanced life support, ground ambulance transportation when **all** of the following criteria are met:

- 1. The medical condition of the Member prevents safe transportation by any other means.
- 2. The transportation is for medically necessary care.
- 3. The Member's condition prohibits other forms of transportation.
- 4. The Member is bed confined. (This is defined as; unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair.)
- 5. Other means of transportation is contraindicated for medical reasons. Examples include, but are not limited to the following:
 - a. The Member cannot safely sit upright while seated in a wheelchair.
 - b. The Member can tolerate a wheelchair, but is medically unstable.
 - c. The Member requires oxygen and oxygen saturation level monitoring, in the absence of a portable oxygen system, to treat hypoxemia, syncope, airway obstruction and/or chest pain.
 - d. The Member requires skilled/trained monitoring during transport due to one of the following:
 - 1) Is comatose
 - 2) Requires airway monitoring
 - 3) Requires cardiac monitoring
 - 4) Is dependent on a ventilator

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by the ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance, and that I have personal knowledge of the patient's condition at the time of transport.

Signature of Physician or Healthcare Professional:	Printed Name of Physician/Healthcare Professional:	Date:
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MEDICAL NECESSITY

Member was informed that transport is not medically necessary by _____

WAIVER INFORMATION

"I have been advised by _____ that this is not a Medicare covered service, and that my insurance company may also regard this as a non-covered service. If, as a result, my insurance company does not pay for this service, I agree to be personally and fully responsible for payment."

Member' Signature	Date:
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