Atlantic Health System
Atlantic Mobile Health

Transport Request Form **Fax: 973-535-0681**

☐ BLS ☐ MAV / Wheelchair
Phone: 866-252-7980 (option 2)

☐ SCTU (nurse)
Phone: 973-422-7701

Round Trip: ☐ Yes ☐ No

Psychiatric: ☐ Voluntary ☐ Involuntary

Last Name	First Name	MI

Date of Birth	Age	Patient Height	Patient Weight (lbs)

Type of Transport: ☐ Dialysis Chair Days: _____
☐ Discharge ☐ Dr. Appt ☐ Wound Care ☐ Radiation/Chemo
☐ Radiology ☐ Special Procedure ☐ Other: _____

Steps at Location
Inside: _____
Outside: _____

Transportation Information **(CMN is valid for round trips on this date & for all repetitive trips in the 60-day range as noted below)**

Date of Transport	Requested By	Phone Number	
Pick Up Time STAT ☐	Transport From	Floor/Unit Bed	Phone Number
Appointment Time	Transport To	Floor/Unit Bed	Phone Number

☐ Yes ☐ No Is the patient's stay covered under Medicare Part A (PPS/DRG?)
☐ Yes ☐ No Is the patient going to the closest appropriate facility? If no, why is transport to the more distant facility required? _____

If Hospital to Hospital transfer, describe services needed at 2nd facility not available at the 1st facility:
(If hospice patient) ☐ N/A Is this transport related to the patient's terminal illness? ☐ Yes ☐ No

Insurance Provider	Bill Facility** ☐	Policy #	Authorization #

Insurance Information
*****Bill Facility requires a name approving the case in the authorization # box***

Medical Necessity Questions

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the **MEDICAL CONDITION** (physical and/or mental) of this patient **AT THE TIME OF AMBULANCE TRANSPORT** that requires the patient to be transported in an ambulance and why transport by other means id contraindicated by the person's condition:

2) ☐ Yes ☐ No Is the patient "Bed confined"? To be "**BED CONFINED"** the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair.

3) ☐ Yes ☐ No Can this patient be safely transported by car or wheelchair van (i.e., seated during transport, without medical attendant monitoring)?

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply* and circle or underline appropriate part to checkbox:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records / *Contact Precautions condition should be listed in #1*

- ☐ **ALS / RN Care Required (SCTU)**
- ☐ **IV MEDS / Fluids Required**
- ☐ **EKG Monitoring Required**
- ☐ **Ventilator / Advanced Airway / Trach**
- ☐ **Hemodynamic Monitoring**
- ☐ Contractures
- ☐ Non-healed Fractures
- ☐ Patient is Confused
- ☐ Patient is Comatose
- ☐ Moderate / Severe Pain on Movement
- ☐ Danger to self / others / combative
- ☐ Need or possible need for restraints
- ☐ Orthopedic Device
- ☐ DVT required elevation of a lower extremity
- ☐ Medical Attendant Required
- ☐ Requires Oxygen – Unable to self-administer: ___ LPM via _____
- ☐ Special Handling / Isolation / Infection control precautions required
- ☐ Unable to tolerate seated position for time needed for transport
- ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
- ☐ Morbid obesity requires additional personnel and equipment to safely handle the patient

5) Describe all **MEDICAL DEVICES** (Medication Pump, Chest Tubes, LVAD etc.) that will be managed by the healthcare provider during transport:

SIGNATURE OF PHYSICAN OR HEALTHCARE PROFESSIONAL

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 ambulance and that other forms of transport are contraindicated. 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 services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services, or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CGR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:

Signature of Physician* or Healthcare Professional	Date Signed
Printed Name & Credentials of Physician or Healthcare Professional (MD, DO, RN, ETC)	**(For Scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date)**

**Form must be signed only by the patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner