RESET FORM

Jan-Care Ambulance Service Inc./GEMS Request for Txp/PCS 1-800-658-6009 fax 888-586-9105

Patient's Name:_____ Date of Birth:_____ Insurance:_____

Transport Date:_____ Transport Pick up time_____ Weight:_____ Require Bari:_____

Origin:_____ Destination:_____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO COVID-19 Positive? ☐ Yes ☐ No

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

Last set of Vitals: B/P _____/____ Pulse:_____ Spo2_____ Resp_____BS_____ Vent: Y N ☐ NIV/BiPAP ☐ SIMV ☐ AC

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe:_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

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 is contraindicated by the patient's condition(include special equipment such as vent/IV etc):

_____

_____

_____

2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
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) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?)
☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement

☐ Danger to self/other ☐ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints

☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self administer

☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport

☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify) ☐ ArtLine-Monitored ☐ Levophed ☐ Neosynephrine ☐ Dobutamine/Dopamine ☐ Vasopressin ☐ Epinephrine

☐ Chest Tube ☐ Arterial Sheath ☐ Foley constant irrigation ☐ Pacemaker int/ext ☐ Bipap

SECTION III – SIGNATURE OF PHYSICIAN 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 CFR §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
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.) **Form must be signed only by 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* ☐ *Discharge Planner* *Call back number #*
☐ *Nurse Practitioner* ☐ *Social Worker* ☐ *Case Manager* ☐ *Licensed Practical Nurse*

First Review Second Review