UVA Health

1200012

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Certification of Medical Necessity for Specialty Care Transport

SECTION I – GENERAL INFORMATION

Patient Name: _____ **Date of Birth:** _____ **Transport Date:** _____

Origin: _____ **Destination:** _____

Mode of Transport: ☐ Ground Ambulance ☐ Helicopter ☐ Fixed-wing Aircraft

Primary Diagnosis: _____

Patient Acuity Level:

☐ Emergent	☐ Urgent	☐ Non-Emergent
IMMEDIATE LIFE-THREATENING CONDITION	SERIOUS CONDITION REQUIRING RAPID TRANSPORT	MEDICAL NECESSITY FOR SPECIALIZED CARE

SECTION II – MEDICAL NECESSITY

Please check all applicable clinical indications that support the need for specialty care transport:

☐ Time-Sensitive Condition:	The patient presents a medical condition necessitating expeditious and immediate transport, due to the inherent nature and gravity of their illness or injury. Ground transportation exceeding a duration of 30 minutes would jeopardize the patient's life or well-being.
☐ Advanced Airway Management:	The patient requires advanced airway interventions, such as intubation or ventilation.
☐ Severe Burns:	The patient has severe burns requiring specialized burn care.
☐ Cardiopulmonary Compromise:	The patient has cardiopulmonary compromise, including acute myocardial infarction, severe heart failure, or respiratory failure.
☐ Hemodynamic Instability:	The patient is experiencing severe instability in blood pressure, heart rate, or perfusion.
☐ Infectious Disease Isolation:	The patient has a highly contagious infectious disease necessitating isolation during transport.
☐ Multi-System Trauma:	The patient has multiple traumatic injuries requiring specialized trauma care.
☐ Neonatal/Pediatric Critical Care:	The patient is a neonate or pediatric patient with critical care needs.
☐ Neurological Emergency:	The patient has a critical neurological condition, such as a stroke, intracranial hemorrhage, or severe head injury.
☐ Obstetric Complications:	The patient has obstetric complications requiring urgent intervention.
☐ Organ Transplant:	The patient is a candidate for or recipient of organ transplantation.
☐ Other (Specify):	_____

SECTION III – PHYSICIAN OR HEALTHCARE PROFESSIONAL ATTESTATION

I hereby certify the accuracy and truthfulness of the aforementioned information, as determined through medical evaluation of the patient. I affirm that the patient necessitates specialty care ambulance transportation, and that alternative modes of transport are medically contraindicated. I acknowledge that this information will be utilized to substantiate the medical necessity for specialty care ambulance services, and I further affirm my personal knowledge of the patient's condition at the time of transport.

_____ Signature of Physician or Healthcare Professional

_____ Date Signed

_____ Printed Name and Credentials of Physician or Healthcare Professional

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

☐ If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance services claim and that the institution with which I am affiliated has provided care, services, or assistance to the patient. My signature above is made on behalf of the patient. My signature is not an acceptance of financial responsibility for the services rendered. The specific reason(s) for the patient's inability to sign the claim form are as follows: