Instructions to Complete the Statewide Ambulance Certification Form

**Section 1 – Patient Personal Information**

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| Patient’s Name and Address | | Enter the patient’s Last Name, First Name. A complete and correctly spelled name is crucial for proper patient identification. Enter the patient’s home address. If the patient is a resident of an inpatient facility, enter the name and address of the facility along with room and bed number. | | |
| Telephone Number | | Contact telephone number for patient, if at home, or for responsible staff person at facility | | |
| Date of Birth | | Enter the patient’s date of birth as mm/dd/yyyy. | | |
| Patient’s Social Security # | | The patient’s social security number is optional. | | |
| Patient’s 11-digit MA # | | Enter the patient’s 11-digit Medical Assistance number. Do not enter the MCO identification number. | | |
| Patient’s Medicare # | | If applicable, enter the patient’s 9-digit Medicare number along with the applicable “letters” | | |
| Other Insurance | | If applicable, enter other insurance information – ID number and name of other insurance | | |
| Recipient Covered Under  Skilled Nursing Benefit? | Check **Yes** or **No.** Form will be returned if response is not checked. | | |  |
|  | | | |
| **Section 2- Patient Medical Information** | | | | | | |
| List Underlying Medical Diagnosis and Medical Condition | | | | Do Not Enter ICD or DSM Codes. Information supplied will be used to determine the necessity of ambulance transport | | |
| Can Patient be Transported by Sedan or Wheelchair Van | | | | Check **Yes** or **No** | | |
| Is the Patient Bed Confined | | | | Review the criteria listed on the form for the definition of “Bed Confined.” All 3 criteria must be met. Answer **Yes** or **No** as appropriate. | | |
| If Not Bed Confined, Reason(s) Why Ambulance Service is Needed | | | | Check all that apply. Use Other to describe any condition not listed that justifies ambulance transport | | |

**Section 3 – Use of Ambulance for Facility Discharges and Transfers**

|  |  |
| --- | --- |
| **Name of Sending Facility** | Where recipient will be picked up |
| Street Address | Provide complete street address |
| Floor /Room/Suite | Recipient’s location within the facility |
| Telephone Number | Contact telephone number for responsible staff person at pick-up facility |
| **Name of Receiving Facility** | Where recipient will be delivered |
| Street Address | Provide complete street address |
| Floor/Room/Suite | Specific location in receiving facility where recipient is to be delivered |
| Telephone Number | Contact number for responsible staff person at receiving facility |

**Provider’s Certification and Signature**

|  |  |  |
| --- | --- | --- |
| Provider Type | Check appropriate. Only Physician and CRNP are “Authorized” to certify |  |
| Signature of Provider | Signature of provider is mandatory or will be returned which will delay transportation services |
| Date Signed | Enter date signed |
| Provider’s Medical Assistance  Or NPI # | Used to verify provider’s participation in the Medical Assistance Program |
| Provider’s Telephone # | Enter Provider’s telephone number in the event we need to contact you |
| Provider’s Full Address | Enter Provider’s full address |

**Form Expiration Dates – Nursing Home and Home Bound Recipients – 90 Days from “Date Signed”**

* **Inter-Hospital Transports – Each Trip**

**The Local Transportation Program Reserves the Right to Request a New Certification More Frequently As Deemed Necessary**