MEDICAL NECESSITY FORM

NON-EMERGENCY MEDICAL TRANSPORTATION

PATIENT INFORMATION
PATIENT NAME:
DOB:
INSURANCE/MEDICARE #:

PROVIDER INFORMATION

FAMILY CARE MEDICAL TRANSPORTATION

OFF: 909-455-6950 FAX: 360-323-9228

WWW.FCMEDICALTRANSPORT.COM

PROVIDER ID#

DATE OF REQUESTED	TRANSPORT BEGIN DATE	TRANSPORT END DATE
/ /	/ /	/ /
TRANSPORT FROM:	**TRANSPORT TO:**	**REASON FOR TRANSPORT**
_____	_____	_____

Please certify that all of the following requirements are met:

☐ Non Ambulatory (Wheelchair) — Patient is physically capable of being transported safely by wheelchair. A wheelchair bound patient has a temporarily or permanently physical disability, which precludes transportation in a motor vehicle or motor carrier that has not been modified or created for transporting a person with a disability. (Ex. Patient is unable to transfer unassisted from a residence to a public or private conveyance because of a physical or mental disability; patients who suffers from severe mental confusion; patients with paraplegia; dialysis patients; patients with chronic condition who require oxygen but do not need monitoring; chemotherapy patients; rehabilitation patients, etc.)

☐ Non Ambulatory (Bed confined) — Patients who has a permanent or temporary disability, which precludes transportation in a motor vehicle or motor carrier that has not been modified or created for transporting a person with a disabling condition. (Ex. Unable to ambulate(walk); unable to get out of bed without assistance; unable to safely sit up in a wheelchair for the period of time needed for transport and requires to be transported in a prone/supine position; stable, post-operative patients; patients with chronic condition who requires oxygen but do not need monitoring)

Please describe medical conditions which would requires the patient to use Ambulate/Litter.

Please describe the patient's medical condition that requires the patient to use an Ambulate/Litter Van service in basic terms. The description of the patient's medical condition should support the above information. (Please include ICD Diagnosis Codes):

Please list any other comment/concerns/explanations. (Optional)

(Ex. Extra attendants)

I certify that the above information is true and accurate based on my evaluation of this patient to the best of my knowledge, and represent that the patient requires transportation by Ambulate/Litter Van due to the reason documented above. The requested services are medically described and necessary to the health of the patient. I understand that this information will be used by various insurance provider, Medicare and Medicaid Services (CMS), etc., to support the determination of medical necessity for Ambulate/Litter Van, and that I have personal knowledge of the patient's condition at the time of transport.

Signature of Physician/Healthcare Professional:	Printed/stamped Name of Physician/Healthcare Professional: License #:	Date:

Fax Completed Form to Family Care Medical Transportation at (360)323-9228 with completed Confirmation