

Section 1: General Information

Patient Name: _____ Date of Birth: _____ Date of Transport: _____
 Originating Facility: _____ Destination Facility: _____

CMS rules and regulations require that the patient is transported to the closest hospital with capability and capacity to care for them

Is the patient being transported to the closest facility that has the **capability and capacity** to provide them with the needed care? Yes No
IF NO, why is the patient being transported to another facility?:

What interventions or services is the patient receiving at the destination facility that are not available at the sending facility?:

Section 2: Medical Necessity

Critical Care Transport is deemed necessary when a patient must be transported to receive interventions or services not available at the sending facility, and the level of care required exceeds that which can be provided by a Maine licensed Paramedic.

Describe the medical condition at the time of transport that requires the patient to be transported by the critical care transport team, and why other methods of transportation are contraindicated. Please include as much detail as possible.

Section 3: Reasonableness

A trip is reasonable when it utilizes the most appropriate type of vehicle for the patient condition, regardless of the availability of other alternatives.

Regarding the patient, please check all that apply.*

<input type="checkbox"/> An intervention is required within a discrete time period.	<input type="checkbox"/> Alternate means of transport would increase risk of harm to the patient.
<input type="checkbox"/> Transport is emergent and time-dependent.	<input type="checkbox"/> Therapies will likely need to be adjusted / titrated during transport.
<input type="checkbox"/> Patient is unstable or has a high likelihood of instability.	<input type="checkbox"/> Extended out of hospital time may pose a danger to the patient.

**Please note, the presence of a checked condition above will not alone establish necessity and reasonableness, but rather support the mode of transport.*

Section 4: Certification

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

Emergency transportation is based on certification of medical necessity from the appropriate ordering provider for which prior authorization is not required under federal law (25 C.F.R. Section 2590.715-2719-A), Medicare Advantage rules (42 CFR 410.40; Medicare Managed Care Manual, Chapter 4, Section 20.3, or Maine law (24-A M.R.S. Section 4320-C). I further certify that this transport was emergent.

If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form 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:

X _____
 Signature of Physician* or Authorized Healthcare Professional _____ Date Signed _____

Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)