Reset Form

Ohio Department of Job and Family Services

Ambulance

Certification of Medical Necessity

1. Patient' s Name
2. Patient's Address
3. Patient's Medicaid Billing Number
4. Ambulance Medicaid Provider Name
5. Ambulance Medicaid Provider Number

6. Date(s) of (First) Transport

7. Why must the patient use an Ambulance instead of other types of transport? (Check One)

☐ **Non-ambulatory** — The patient is non-ambulatory and is unable to get up from bed without assistance. The patient is unable to sit in a chair or wheelchair and the patient can only be moved by a stretcher or needs to be restrained.

☐ **Medical Supervision** — Patient requires continuous medical supervision or treatment during transport.

☐ **Oxygen Administration** — Patient requires oxygen administration during transport and the patient is unable to self - administer or self-regulate the oxygen or the patient requiring oxygen administration has been discharged from a hospital to a nursing facility.

8. What medical condition requires the patient to use an Ambulance?

Please describe the patient's medical condition that requires the patient to use an ambulance in terms that an average person could understand. The description of the patient's medical condition should support the item(s) checked in number 7.

9. How long may the patient require an Ambulance for transportation?

☐ **Temporary** (not to exceed 90 days) — Patient is expected to need an Ambulance for transport for ☐ days from the date of first transport because of the reason(s) checked in number 7 and the medical condition(s) identified in number 8. This certification form is valid for the estimated length of time as designated by the attending practitioner.

☐ **Permanent** — The patient is expected to need an Ambulance for transport for at least 365 days from the date of the first transport.

10. Are there any other comments or explanations? (Optional)

11. Who is the attending practitioner that has ordered the Ambulance transport?

A. Attending Practitioner ordering this medical transport: (Please Print Name)	B. Attending Practitioner Provider Number (Do not use 9111115)

12. Who is the attending practitioner or R.N./discharge planner that is signing?

A. Signature & Professional Letters (i.e. MD, DO, RN, APN, LSW etc.)	B. Signature Date

BIN 1005.2 Instructions for the JFS 00000 Ambulance Certification of Medical Necessity

1. **Patient's Name** - Enter the name of the patient being transported.

2. **Patient's Address -** Enter the address of the patient being transported.

3. **Patient's Medicaid Billing Number** - Enter the patient's Medicaid billing number as it appears on their Ohio Medicaid Card.

4. **Ambulance Medicaid Provider Name** - Enter the name of the provider of Ambulance service(s.)

5. **Ambulance Medicaid Provider Number** - Enter the seven digit Medicaid number of the provider of Ambulance service(s.)

6. **Date(s) of (First) Transport -** Enter the first date of transport, date of transport or range of dates of transport as applicable.

7. **Why must the patient use an Ambulance instead of other types of transport?** - Place a check mark in all applicable reason(s) why the patient cannot use other types of transport and must use an Ambulance.

8. **What medical condition requires the patient to use an Ambulance?** - Describe the patient's medical condition that precludes this patient from using other transport and certifies that using an Ambulance is medically necessary. The description should be in terms that an average person could understand. An ICD-9 code and its description may be included as part of the response. The description of the medical condition should support the reason indicated in number 7.

9. **How long may the patient require an Ambulance for transportation?** - – Indicate whether the patient requires an Ambulance for transportation on a temporary or permanent basis by placing a check mark in the appropriate box. If temporary, enter the number of days from the date of first transport that the patient is expected to need an Ambulance in the box provided. If the length of time exceeds 90 days a new certification form must be obtained.

10. **Are there any other comments or explanations? (Optional)** - Area to be used as needed to make additional comments or notations. For example, a provider may use this area to document the need and use of additional attendants. This area may also be used to document the reason ambulette services were provided by a ground ambulance vehicle. In addition, the area may be used to document the reason for transport to a destination outside the patients community (a fifty mile radius from patient's residence) or to explain excessive mileage or an unusual destination that was prior authorized.

11. **Who is the attending practitioner (Medicaid Provider) that has ordered the Ambulance transport?**

    A. **Attending Practitioner** - Please print the name of the attending practitioner who is ordering this medical transport.

    B. **Attending Practitioner Provider Number (Do not use 9111115)** - Enter the seven digit Medicaid provider number of the attending practitioner who is ordering the medical transport.

12. **Who is the attending practitioner or R.N. that is signing?**

    A. **Practitioner's Signature & Initials (i.e. MD, DO, RN, APN, LSW)** - An original signature of the attending practitioner (M.D., D.O., D.P.M., L.S.W., or A.P.N. who holds a Certificate of Authority or a Notice of Approval) is required. A registered nurse or a discharge planner, with the consent of the attending practitioner, may write the practitioner's name on the signature line and sign his or her own first name, last name, and nursing skill level (if applicable) after the practitioner's name. A discharge planner must be employed by the hospital where the patient is being treated and from which the patient is transported in order to complete this section as specified above. In addition, the discharge planner must be a licensed social worker who is practicing within their scope of practice in accordance with chapter 4757 of the Administrative Code.

    B. **Signature Date** - The date the attending practitioner signed the form.

Note: This form is non-transferable between Ambulance providers.

This form is required as a certification of medical necessity of transport to medicaid-covered services in accordance with chapter 5101:3-15 of the Administrative Code.