

Patient Name: _____ Transport Date: _____

Privacy Practices Acknowledgment: by signing below, the signer acknowledges that **Superior Ambulance Svc, Inc. (SAS)** provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

*** A copy of this form is as valid as an original***

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to me by [SAS] now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by [SAS], regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to [SAS] any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to [SAS]. I authorize [SAS] to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to [SAS] and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payors or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by SAS, now, in the past, or in the future.

If the patient signs with an "X" or other mark, a witness should sign below

X _____ X _____
Patient Signature or Mark Date Witness Signature Date

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.

On the line below, explain the circumstances that make it impractical for the patient to sign:

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by [SAS] now or in the past, (or in the future, where permitted). By signing below, I acknowledge that I am one of the following: (1) the patient's legal guardian; (2) a relative or other person who receives social security or other governmental benefits on the patient's behalf; (3) a relative or other person who arranges for the patient's treatment or exercises other responsibility for his or her affairs; and/or (4) a representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the pt
My signature is not an acceptance of financial responsibility for the services rendered.

X _____
Representative Signature Date Printed Name and Address of Representative

Check this box if the representative signer is the patient's: (1) legal guardian, or (2) health care power of attorney

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, **and**
(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

On the line below, explain the circumstances that make it impractical for the patient to sign:

Name and Location of Receiving Facility:

Time at Receiving Facility:

X _____
Signature of Crewmember Date Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature

The patient named on this form was received by this facility at the date and time indicated above. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.**

X _____
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____
Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)
Origin: _____ Destination: _____
Is the pt's stay covered under Medicare Part A (PPS/DRG?) YES NO
Closest appropriate facility? YES NO If no, why is transport to more distant facility required? _____
If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____
If hospice pt, is this transport related to pt's terminal illness? YES NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

- 1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

 - 2) Is this patient "bed confined" as defined below? Yes No
To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair

 - 3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?)
 Yes No

 - 4) **In addition** to completing questions 1-3 above, please check any of the following conditions that apply*:
*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records
- Contractures Non-healed fractures Patient is confused Patient is comatose Moderate/severe pain on movement
 Danger to self/other IV meds/fluids required Patient is combative Need or possible need for restraints
 DVT requires elevation of a lower extremity Medical attendant required Requires oxygen – unable to self administer
 Special handling/isolation/infection control precautions required Unable to tolerate seated position for time needed to transport
 Hemodynamic monitoring required enroute Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
 Cardiac monitoring required enroute Morbid obesity requires additional personnel/equipment to safely handle patient
 Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
 Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

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

Signature of Physician* or Healthcare Professional

Date Signed
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

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

*Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):

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