

AMBULANCE MEDICAL NECESSITY FORM

ADVANCED LIFE SUPPORT

NH Medicaid and Healthy Kids-Gold (NH Title XIX) benefits are payable for ambulance services provided to eligible NH Title XIX recipients only when the use of any other method of transportation is medically contraindicated by that patient's condition and only when the medical necessity for the ambulance services is documented, as required by the Centers for Medicare & Medicaid Services (CMS).

The Advanced Life Support Ambulance Medical Necessity Form must be completed by someone with medical knowledge of the case and be signed by one of the following: physician, doctor of osteopathy, advanced practice registered nurse, physician assistant, clinical nurse specialist, registered nurse, or discharge planner. Documentation of medical necessity must be kept on file to support each claim submitted to NH Title XIX. A copy of this form must be attached to the CMS 1500 claim form if billing by paper.

Patient Name: _____ DOB: _____

Patient's NH Medicaid ID# (11 digits): _____

Ambulance

Dispatched to: _____ Date Dispatched: _____

Patient taken to: _____

1. Suspected Diagnosis or Presenting Symptoms:

- | | | |
|---|---|---|
| <input type="checkbox"/> Cardiac arrest | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Respiratory Arrest |
| <input type="checkbox"/> Unconscious | <input type="checkbox"/> Shock | <input type="checkbox"/> Burns |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Respiratory Distress | <input type="checkbox"/> OD/Poison |
| <input type="checkbox"/> Dizziness or Syncope | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Trauma: _____ | | |
| <input type="checkbox"/> Acute Medical: _____ | | |
| <input type="checkbox"/> Chronic Medical: _____ | | |

2. Emergency Care:

- | | | |
|---|--|---|
| <input type="checkbox"/> CPR | <input type="checkbox"/> EOA/EGTA Placement | <input type="checkbox"/> Extrication |
| <input type="checkbox"/> Endotracheal Tube Placement | <input type="checkbox"/> Bleeding Control | <input type="checkbox"/> EKG (circle one): Monitor Telemetry |
| <input type="checkbox"/> O ₂ Ventilation and Route | <input type="checkbox"/> I.V. Therapy | <input type="checkbox"/> Back/Neck Immobilization |
| <input type="checkbox"/> MAST Trousers | <input type="checkbox"/> Splint/Traction Applied | <input type="checkbox"/> Defibrillation |

3. Other Pertinent Information: _____

Name of person completing this form: _____

(Please type or print)

Ambulance Provider Number: _____

Signature of (circle one) MD DO APRN PA CNS RN Discharge Planner If not an MD or DO, signer is indicating that s/he has personal knowledge of the recipient's condition at the time the ambulance transport is ordered, or the service is furnished, and the signer is employed by the recipient's attending physician or by the hospital or facility where the recipient is being treated and from which the recipient is transported.

Signature

Date