

## AMBULANCE MEDICAL NECESSITY FORM

### BASIC 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 Basic 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. Please describe the patient's condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Was the patient ambulatory?  Yes  No

3. Could other means of transportation (automobile, chair car, van, public transportation) have been used without endangering the patient's condition?  Yes  No

4. If the patient was transported to the outpatient department of a hospital, indicate the services performed:

- Scheduled Clinic Visit
- Emergency Services
- X-ray (specify type) \_\_\_\_\_
- Other (specify type) \_\_\_\_\_

5. If the patient was transferred from one institution to another, please give reason: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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