CERTIFICATION OF MEDICAL NECESSITY FOR NON-EMERGENCY AMBULANCE TRANSPORT

Please complete this form and fax back to Amerigroup Transportation at 678-510-1354 to receive authorization to transport the Amerigroup Member.

SECTION I - PATIENT IDENTIFICATION

Patient's Last Name	Patient's First Name	Patient's M.I.	Suffix

Date of Birth	Medicaid ID	Social Security Number

SECTION II - TRANSPORT INFORMATION

Transport Date (This document is valid for round trips on this date and for recurring trips in the 60-day range as noted below): ____/_____/_____

Example:		Origin Location (enter info below)		Destination Location (enter info below)	
Facility Name (if applicable)					
Facility NPI (if applicable)					
Street Address					
City					
State	Zip	State	Zip	State	Zip

Closest appropriate facility?	☐ Yes ☐ No If no, why is transport to more distant facility required? _____ _____
Hospital to hospital transfer?	☐ Yes ☐ No

The purpose of this trip is (check all that apply):	☐ Dialysis ☐ Behavioral Health ☐ Hospital transfer to a higher level of care ☐ Morbid obesity requires additional personnel/equipment (**Patient Weight? _____ lbs.**) ☐ IV meds/fluids required during transport ☐ Other condition that necessitates ambulance service: _____
Are recurring trips needed?	☐ Yes ☐ No If yes, what is the frequency and duration? _____

SECTION III – PATIENT CONDITION

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; (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair		
Can the patient safely be transported by car or wheelchair van? If yes, your facility could be held responsible for payment of ambulance claim.	Yes ☐	No ☐

SECTION IV – ATTESTING PARTY (must be completed by treating MD/NP/PA/RN)

I certify that the above information is true and correct based on my evaluation of this patient, that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that the State of Louisiana uses this attestation to determine the necessity of ambulance transportation and the appropriate payment to ambulance providers. I understand that this document may be subject to review by the Department of Health and Hospital or its designee and any misrepresentation of the above facts could result in monetary penalties assessed to me or the facility I represent as stated below.

Clinician Name (Print):	Phone:
Clinician Title: ☐ MD ☐ NP ☐ PA ☐ RN	
Clinician NPI:	Facility Name:
Clinician Signature:	**Date:**