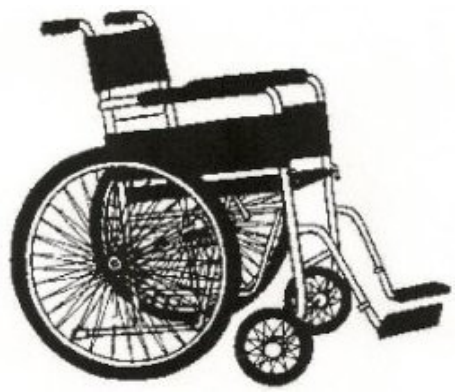

AMBULETTE

CERTIFICATION OF MEDICAL NECESSITY

PATIENTS NAME
PATIENTS MEDICAID BILLING NUMBER
PATIENTS ADDRESS
AMBULETTE MEDICAID PROVIDER NAME **EASTERN AREA SPECIALTY TRANSPORT**
AMBULETTE MEDICAID PROVIDER NUMBER **2212993**

DATE(S) OF TRANSPORTATION:

CERTIFY THAT THE FOLLOWING CRITERIA HAVE BEEN MET (ALL THREE BOXES MUST BE CHECKED)

☐ **NON-AMBULATORY** THE PATIENT IS NON-AMBULATORY. A PATIENT IS NON-AMBULATORY IF THEY HAVE A PERMANENT OR TEMPORARY DISABLING CONDITION, WHICH PREVENTS THEM FROM BEING TRANSPORTED IN A VEHICLE THAT HAS NOT BEEN DESIGNED FOR TRANSPORTING A PERSON WITH A DISABLING CONDITION.

☐ **WHEELCHAIR** PATIENT IS PHYSICALLY ABLE TO BE SAFELY TRANSPORTED IN A WHEELCHAIR

☐ **NO AMBULANCE** PATIENT DOES NOT NEED AN AMBULANCE

MEDICAL REASON PATIENT NEEDS TO USE AN AMBULETTE

DESCRIBE IN A SHORT NARRATIVE THE PATIENT'S CONDITION THAT REQUIRES THEM TO BE TRANSPORTED IN A WHEELCHAIR

LENGTH OF TIME PATIENT REQUIRES AMBULETTE FOR TRANSPORTATION

ENTER NUMBER NO GREATER THAN 90 DAYS

☐ **TEMPORARY** (NOT TO EXCEED 90 DAYS) PATIENT IS EXPECTED TO NEED AN AMBULETTE FOR TRANSPORT FOR _____ DAYS FROM THE DATE OF FIRST TRANSPORT BECAUSE OF THE MEDICAL CONDITION(S) IDENTIFIED ABOVE. THIS CERTIFICATION FORM IS VALID FOR THE ESTIMATED LENGTH OF TIME AS DESIGNATED BY THE ATTENDING PRACTITIONER.

☐ **PERMANENT** PATIENT IS EXPECTED TO NEED AN AMBULETTE FOR TRANSPORT FOR AT LEAST 365 DAYS FROM THE DATE OF THE FIRST TRANSPORT.

ADDITIONAL COMMENTS OR EXPLANATIONS (OPTIONAL)

ATTENDING PRACTITIONER ORDERING AMBULETTE TRANSPORT

PRINT NAME OF ORDERING PHYSICIAN

NOTE: FOR REPETITIVE TRANSPORTS (DIALYSIS. RADIATION THERAPY, PHYSICAL THERAPY, ETC) THE ATTENDING PHYSICIAN MUST SIGN THIS FORM PRIOR TO THE FIRST TRANSPORT.

AUTHORIZED SIGNATURE (ATTENDING PHYSICIAN, R.N., DISCHARGE PLANNER)

SIGNATURE & PROFESSIONAL LETTERS (MD, DO, RN,LSW ETC)	PRINTED NAME	SIGNATURE DATE

EASTERN AREA SPECIALTY TRANSPORT .INC 1000 INDUSTRIAL DRIVE LEESBURG, OHIO 45135

Revised 08/06/2010