



PHYSICIANS

Ambulance & Wheelchair Service

25975 Emery Road, Suite A • Warrensville Heights, Ohio 44128

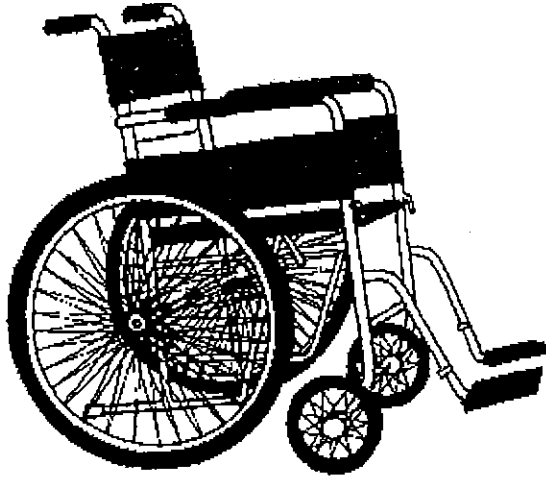
Dispatch 216-454-4911

Fax Number 216-332-1669

Ohio Department of Job and Family Services

Ambulette

Certification of Medical Necessity



1. Patient's Name
2. Patient's Address
3. Patient's Medicaid Billing Number
4. Ambulette Medicaid Provider Name Physicians Ambulance
5. Ambulette Medicaid Provider Number 2234933

6. Date(s) of (First) Transport

7. Please certify that ALL of the following criteria have been met.

- Non-ambulatory** The patient is non-ambulatory. A patient is non-ambulatory if they have a permanent or temporarily disabling condition, which precludes transportation in a motor vehicle or motor carrier that has not been modified or created 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.

8. What medical condition requires the patient to use an Ambulette?

Please describe the patient's medical condition that requires the patient to use an ambulette in terms that an average person could understand. The description of the patient's medical condition should support that all of the criteria in number 7 was met.

9. How long may the patient require an Ambulette for transportation?

- 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 in number 8 and because they meet all of the criteria in number 7. This certification form is valid for the estimated length of time as designated by the attending practitioner.
- Permanent** The patient is expected to need an Ambulette for transport for at least 365 days from the date of the first transport.

10. Are there any other comments or explanations? (Optional)

11. Who is the attending practitioner that has ordered the Ambulette transport?

A. Attending Practitioner ordering this medical transport: (Please Print Name)

B. Attending Practitioner Provider Number (Do not use 9111115)

12. Who is the attending practitioner or R.N./discharge planner that is signing?

A. Signature & Professional Letters (i.e. MD, DO, RN, APN, LSW)

B. Signature Date