Urgent Care EMS Date: **Run #** 19- **Intake:** **Input:**

Time/Miles Unit #_____

Received _____:_____

Dispatch _____:_____

Enroute _____:_____ _____ Beginning Mileage

At Scene _____:_____

PT Contact _____:_____ _____ At Scene Mileage

Left Scene _____:_____

Destination _____:_____ _____ At Dest Mileage

In Service _____:_____

Notes: _____ **Shoulder Straps Yes or No**

INCIDENT LOCATION			TRANSPORTED TO		
PATIENT INFO	PATIENT LAST NAME FIRST M.I.		PHONE	DOB	
	STREET ADDRESS		SSN #	AGE	GENDER M☐ F☐
	MAILING ADDRESS		FAMILY PHYSICIAN		
	CITY STATE ZIP		RACE ☐W ☐B ☐H ☐O	GCS	WEIGHT (LBS)

GCS

The GCS is a Neurological Exam not a Physical Exam

EYE OPENING		**VERBAL RESPONSE**		**MOTOR RESPONSE**	
Spontaneous	4	Oriented (person, place)	5	Obeys command	6
To Speech	3	Confused	4	Localizes	5
To Pain	2	Inappropriate word	3	Withdraws	4
None	1	Incomprehensible words	2	Flexion	3
		No Response	1	Extension	2
				None	1

INS INFO

MEDICARE #_____-_____-_____-_____MEDICAID#_____

CARRIER:_____POLICY HOLDER'S NAME:_____DOB:_____

CONTRACT #: GROUP #:

CHIEF COMPLAINT		**SECONDAY COMPLAINT**	
ALLERGIES (MEDS)	☐Pt. States None ☐Unknown ☐List:		
MEDICAL HISTORY	☐Pt. States None ☐Dementia ☐Asthma ☐Cardiac ☐COPD ☐Drug/Alcohol ☐Renal Failure ☐Seizure/Convuls ☐Unknown ☐AMS/Behav ☐Cancer ☐CHF ☐Diabetes ☐Hypertension ☐Resp. Failure ☐Stroke/CVA Other HX :		

TIME	BY	BP	P	R	SP02	BG	Notes

How was pt placed on stretcher? ☐Draw Sheet ☐Backboard ☐Manual Lift ☐Mechanical Lift ☐Assisted to Stretcher ☐Walked to Stretcher (Explain in narrative) (AMS?)

Driver **Attendant** **Attendant**

PATIENT INFORMATION FORM

PATIENT INFORMATION:

Last Name:	First Name:	MI:	Suffix
Address:			
Facility Name:	Telephone:		

City:	County:	State:	Zip:

SSN:	Birth date:	Gender:	Age:	Race:

INSURANCE INFORMATION:

Primary Insurance:	
Policy #:	Group ID:
Address:	

Secondary Insurance:	
Policy #:	Group ID:
Address:	

MEDICAL INFORMATION:

Primary Physician:
Allergies:
Medications:
Medical/Surgical Hx:
Chief Complaint:

IN CASE OF EMERGENCY:

Last Name:	First Name:	MI:	Suffix
Address:	Relationship to patient:		

City:	State:	Zip:	Telephone:

TREATING FACILITY:

Dialysis Center:	Time on:
Address:	Time off
Dialysis Transport days:	
Patient Lifetime Signature Obtained? ☐ YES ☐ NO	Date Obtained:

ASSESSMENT OF PATIENT AT TIME OF TRANSPORT

Patient Name:_____ Run # & Date: 19-_____

Limb Amputations: ( ) Yes ( ) No ( ) Old **{More than 6 months}** ( ) New **{Less than 6 months}**
Specific Location: _____

Paralysis : ( ) Yes ( ) No Specific Location:_____
( ) CVA ( ) Spinal Bifida ( ) Multiple Sclerosis ( ) Traumatic ( ) Other:_____

Weakness: ( ) Yes ( ) No Specific Location:_____Why?_____

Contractures: ( ) Yes ( ) No Specific Location:_____

Decubitus/Wound ( ) Yes ( ) No Type:_____Location:_____Stage (if known):_____

Fracture: ( )Hip ( )Pelvis ( )Femur ( ) Less than 6 mo ( ) More than 6 mo Date of Fracture:_____
Cause/Mechanism of Injury:_____

Oxygen Patient: ( ) Yes ( ) No
Does the patient have portable oxygen equipment: ( ) Yes ( ) No
Can the patient self administer/regulate the oxygen: ( ) Yes ( ) No

Altered Mental Status: ( ) Yes ( ) No Glasgow Coma Score at time of transport: _____
( ) Psychosis ( ) Dementia ( ) Alzheimers ( ) Schizophrenia ( ) Bipolar ( ) Other _____

Isolation Precautions: ( ) Yes ( ) No - ( ) MRSA ( ) VRE ( ) C-Diff ( ) Hep _____ Active ( ) Yes ( ) No

Morbid Obesity ( ) Yes ( ) No Weight: _____ Height: _____

Other sign and symptoms presented by the patient today:_____

_____

Reason Patient Requires Stretcher Transport

( ) Advanced Airway Management
( ) Ataxia - Muscular Incoordination
( ) Cardiac/Hemodynamic Monitoring
( ) Pt Has Reduced Level Of Consciousness
( ) Pt Requires IV and Meds Enroute
( ) Pt Safety Risk of Exiting Ambulance Prematurely
( ) Pt Sedated
( ) Required EKG Monitoring
( ) Required Emergency Treatment and Transport
( ) Medical Device Failure (ie: Pacemaker, Peg Tube ec..)
( ) Special Handling - Monitor of Device
( ) Special Handling - Special Position of Patient
If used has to be documented why positioning is needed
( ) Stretcher Req Due to Patient Risk of Falling From Wheelchair

EMT Signature:_____ Date:_____

Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Initial Transport Date: _____ Repetitive Transport Expiration Date (Max 60 Days From Date Signed): _____

Origin: _____ Destination: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR**, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered by the medical professional signing below for this form to be valid:

1) Is this patient "bed confined" as defined above? ☐ Yes ☐ No

2) Describe the Medical CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?)
☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Moderate/severe pain on movement

☐ Danger to self/others ☐ IV meds/fluids required ☐ Special handling/isolation required

☐ Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute

☐ Restraints (physical or chemical) anticipated or used during transport

☐ Patient is confused, combative, lethargic, or comatose

☐ Cardiac/hemodynamic monitoring required enroute

☐ DVT requires elevation of a lower extremity

☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport

☐ Unable to maintain erect sitting position in a chair for time needed to transport

☐ Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks

☐ Morbid obesity requires additional personnel/equipment to safely handle patient

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____ _____

Signature of Physician* or Healthcare Professional Date Signed

_____

Print Name of Physician* or Healthcare Professional & Credentials

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

_____

Treatment Verification Form

The following patient:

_____

Patient Name (Please Print)

was delivered to

_____

Name of Facility

and received treatment on the following date: _____

Date:

_____

Signature of receiving facility representative

_____

Printed name of receiving facility representative

REFUSAL STATEMENT & SIGNATURE

This is to certify that I am refusing assessment, treatment, and/or transport and I have been advised of the risks involved. I understand that I may be billed for the response, assessment and/or treatment that I received.

X_____

Patient Signature **Date**

X_____

Witness Signature **Date**

SIGNATURE FORM - REQUIRED

Patient Name: _____ **Transport Date:** _____

Privacy Practices Acknowledgment: by signing below, I acknowledge that I have received Urgent Care EMS Notice of Privacy Practices.

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Urgent Care EMS

for any services provided to me by Urgent Care EMS, now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by Urgent Care EMS regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to Urgent Care EMS any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Urgent Care EMS. I authorize Urgent Care EMS to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to

release such information to Urgent Care EMS and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Urgent Care EMS, now, in the past, or in the future.

A copy of this form is valid as an original

If the patient signs with an "X" or other mark, a witness should sign below, this can be an ambulance crew member

X_____ _____ X_____ _____
Patient Signature or Mark | Date | Witness Signature | Date

_____
Witness Printed Name

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section <u>only</u> if the patient is physically or mentally incapable of signing.

Reason the patient is physically or mentally incapable to sign: _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Urgent Care EMS** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **<u>only</u>** the following individuals:

- ☐ Patient's legal guardian
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X_____ _____ _____
Representative Signature | Date | Printed Name of Representative

Representative Address: _____

SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **<u>only</u>** if: (1) the patient was physically or mentally incapable of signing, **<u>and</u>**
(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

Reason the patient is physically or mentally incapable to sign:_____

Name and Location of Receiving Facility: _____ Time: _____

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by Urgent Care EMS

A. Ambulance Crew Member Statement (*<u>must</u>* be completed by crew member <u>at time of transport</u>)
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Crewmember | Date | Printed Name and Title of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Receiving Facility Representative | Date | Printed Name and Title of Receiving Facility Representative