Certificate of Medical Necessity for Non-Emergency Ambulance

Hospital to Hospital Transportation

MISSISSIPPI DIVISION OF MEDICAID

Instructions:

This form provides the information needed to make medical necessity determinations for non-emergency hospital to hospital ambulance transports.

Print Beneficiary Name:

First _____

Middle _____

Last _____

Medicare # _____ Medicaid # _____

Other Insurance _____

Date of Transport: _____

Transport from: _____ To:_____

Please document the receiving physician's specialty or facility specialty service which the beneficiary requires that the sending facility could not provide:

Is this the closest appropriate facility that can provide this service? ☐ Yes ☐ No

If no, explain:

Description of the Beneficiary's condition:

_____

_____

_____

_____ _____ _____

Signature of MD, PA, NP, CNS, RN or DC Planner | Title | Date