UnitedHealthcare
Medicare Solutions

Transportation Information and Statement of Medical Necessity
UnitedHealthcare Nursing Home Plan

Section 1: Transportation and Member Demographic Information	
Member Name:	UnitedHealthcare member ID#:
Transportation from:	Transportation to:
Transportation date (indicate date range of up to 60 days for repetitive, scheduled appointments):	
Mode of Transportation: ☐ Wheelchair van ☐ Ambulance (if checked, please complete Section 2) ☐ SCTU **(if checked, please complete Section 2)**	

Section 2: Statement of Medical Necessity for Non-Emergency Ground Ambulance

Does the member have a medical condition requiring non-emergency ambulance transportation in accordance with medical necessity requirements established by the Centers for Medicare and Medicaid Services? If ambulance transportation is medically required, this statement of medical necessity must be made by a physician* directly responsible for the member's care. ☐ **YES** ☐ **NO**

Medical conditions (not diagnosis) at the time of transport – please mark ALL that apply:

- ☐ Orthopedic device requiring special handling (e.g., backboard, halo, use of pins in traction, etc.)
- ☐ Contractures that make the member unable to sit and preclude any significant physical activity
- ☐ Immobility due to unset fracture of the _____(insert body part)
- ☐ Paralysis and/or bed-confined (unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair)
- ☐ Requires airway monitoring or suctioning, or is ventilator dependent
- ☐ Requires isolation precaution
- ☐ Morbid obesity: Member is 100 pounds or more over ideal body weight or has a body mass index (BMI) of 40 or higher, with significant impairments to functionality and requiring additional personnel and/or specialized equipment to safely handle member
- ☐ Other, please specify:

_____

Please describe specifics of condition necessitating ambulance transportation:

I certify that the above information is true and correct based on my evaluation of this patient who is a UnitedHealthcare member, and represent that ambulance transport of the member is medically necessary due to the reasons documented above. I understand that this information will be used by the transportation provider to support the medical necessity for ambulance services, and that I have personal knowledge of the member's condition at the time of transport.

Signature of ordering physician*:	Printed name of ordering physician*:	Date:
National Provider Identifier (NPI):	Phone number:	

When this form is complete, please place a copy in the member's medical record and provide a copy to the transportation provider. If you have questions contact your Provider Advocate.

*The physician order and certification may be signed by a physician assistant, nurse practitioner, or clinical nurse specialist (where all applicable state licensure or certification requirements are met).

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