MEDICARE

Blue Cross
Blue Shield
P.O. Box 2137
Boston, Massachusetts 02108

MEDICAID

Department of Public Welfare
600 Washington Street, Room 740
Boston, Massachusetts 02111
Telephone: 727-8080

AMBULANCE MEDICAL NECESSITY FORM

TRINITY
EMERGENCY MEDICAL SERVICE

1221 Westford Street
Lowell, MA 01851

Lowell
(978) 441-9999

Lawrence
(978) 683-4708

Beneficiary:
H.I.C. Number:
Medicaid Number:
Services by:
Service Date.
Physician's Name:
Address:

MEDICARE PART B - AMBULANCE

Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is medically contraindicated by the patient's condition. The Social Security Administration requires documentation of the medical necessity for such services.

To expedite the processing of an ambulance claim for the above beneficiary, this form should be completed by someone with medical knowledge of the case (physician, R.N., L.P.N.) and then attached to the Medicare Request for Payment Claim form - SSA 1491.

MEDICAID - AMBULANCE OR CHAIR CAR

Please check: 1. ☐ Ambulance or ☐ Chair Car
2. ☐ One Way or ☐ Round Trip

Medicaid will reimburse for ambulance or chair car services only when the use of any other method is contraindicated by the patient's condition. For Medicaid purposes, the attending physician or his/her authorized designee must complete this form. The attending physician's name must be entered above if (s)he does not personally complete this form.

When bill is submitted to Medicaid, please attach this completed form to either MA 8 or MA 10 invoice.

1. Please explain why other means of transportation (automobile, wheelchair, van, taxi, public transportation) could not have been utilized without endangering the individual's health. Please do not use abbreviations.

2. If the patient was transported to the outpatient department, what services were performed ?

   A. A. Scheduled clinic visit: ☐ Yes ☐ No
   B. X-ray (type):
   C. Therapy (type):
   D. Other (please specify):

3. If the patient was transferred from one institution (hospital, nursing home) to another, please give reason.

4. Please indicate specific origin and destination of service (name of facility and / or address):

   Patient transported FROM _____ TO _____

5. FORM COMPLETED BY

   Name (print) _____

   Address _____

   Title _____ Institution Affiliation _____

   Signature _____ Date _____