Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR NON-EMERGENCY TRANSPORTATION BY GROUND AMBULANCE

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*	

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)* South Western Ambulance Service LLC	
5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI) — *10 Digits*

Certification

7. Criteria *(Mark each reason why transport is being certified as necessary for this individual.)*	8. Period Beginning Date *(Enter the first date of the certification period.)*
During transport, this individual requires: ☐ medical treatment or continuous supervision by an EMT. ☐ the administration or regulation of oxygen by another person. ☐ supervised protective restraint.	9. Length *(Mark <u>one</u> box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)* ☐ Not more than day(s) ☐ One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

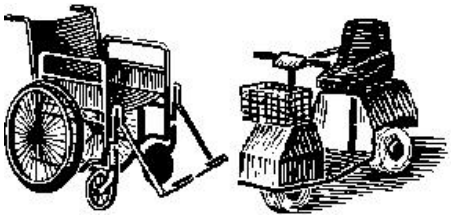
11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*	
12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*	

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.



Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR TRANSPORTATION BY WHEELCHAIR VAN

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*	

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)*	
5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI), If Applicable — *10 Digits*

Certification

7. Criteria *By signing this document, the practitioner certifies that two statements are true:* a. This individual must be accompanied by a mobility-related assistive device from the point of pick-up to the point of drop-off. b. Transport of this individual by standard passenger vehicle or common carrier is precluded or contraindicated.	8. Period Beginning Date *(Enter the first date of the certification period.)* 9. Length *(Mark <u>one</u> box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)* ☐ Not more than day(s) ☐ One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*	
12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

14. Date of Signature	15. Name of Person Signing
16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*	

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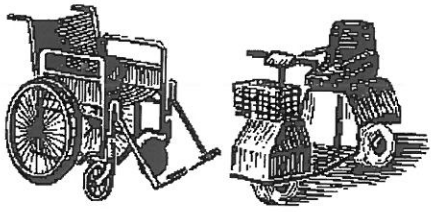

Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR TRANSPORTATION BY WHEELCHAIR VAN

THIS FORM NEEDS COMPLETED PRIOR TO WHEELCHAIR TRANSPORT.

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
PATIENT'S FULL NAME	PATIENT'S MEDICAID # - IF APPLICABLE

3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*

PATIENT'S HOME ADDRESS

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)*

COMMUNITY CARE AMBULANCE

5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI), If Applicable — *10 Digits*

Certification

7. Criteria

By signing this document, the practitioner certifies that two statements are true:

a. This individual must be accompanied by a mobility-related assistive device from the point of pick-up to the point of drop-off.

b. Transport of this individual by standard passenger vehicle or common carrier is precluded or contraindicated.

8. Period Beginning Date *(Enter the first date of the certification period.)*

DATE OF TRANSPORT (XX/XX/XXXX)

9. Length *(Mark <u>one</u> box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)*

☐ Not more than day(s)

☐ One year

1 BOX NEEDS CHECKED WITH # OF DAYS

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

MEDICAL NECESSITY - WHY THE PT CANNOT AMBULATE. (WEAKNESS/FATIGUE/NON-WEIGHTBEARING IS NOT ENOUGH)
DIAGNOSIS WITH CONDITION.

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*

FIRST & LAST NAME OF ATTENDING PHYSICIAN WITH PROFESSIONAL DESIGNATION (MD/DO)

12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

14. Date of Signature	15. Name of Person Signing
DATE OF TRANSPORT (XX/XX/XXXX)	PRINTED NAME OF THE PERSON SIGNING

16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*

SIGNATURE OF THE PERSON SIGNING WITH PROFESSIONAL DESIGNATION. (MD,DO,RN,CNS,PA,NP or DISCHARGE PLANNER)

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Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR NON-EMERGENCY TRANSPORTATION BY GROUND AMBULANCE

THIS FORM NEEDS COMPLETED PRIOR TO AMBULANCE TRANSPORT.

Individual Information

1. Name *(Enter the full name of the individual transported.)*	2. Ohio Medicaid Billing Number — *12 Digits*
PATIENT'S FULL NAME	PATIENT'S MEDICAID # - IF APPLICABLE

3. Address *(Enter the individual's home address. This information may be used to confirm the identity of the individual.)*

PATIENT'S HOME ADDRESS

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)*

COMMUNITY CARE AMBULANCE

5. Ohio Medicaid Provider Number — *7 Digits*	6. National Provider Identifier (NPI) — *10 Digits*

Certification

7. Criteria *(Mark each reason why transport is being certified as necessary for this individual.)* AT LEAST 1 BOX NEEDS CHECKED

During transport, this individual requires:

- ☐ medical treatment or continuous supervision by an EMT.
- ☐ the administration or regulation of oxygen by another person.
- ☐ supervised protective restraint.

8. Period Beginning Date *(Enter the first date of the certification period.)*

DATE OF TRANSPORT (XX/XX/XXXX)

9. Length *(Mark one box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)* 1 BOX NEEDS CHECKED WITH # OF DAYS

- ☐ Not more than day(s)
- ☐ One year

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate

MEDICAL NECESSITY - WHY THE PATIENT IS BEING TRANSPORTED IN THIS MODE. (WEAKNESS/FATIGUE/NON-WEIGHTBEARING IS NOT ENOUGH) DIAGNOSIS WITH CONDITION.

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*

FIRST & LAST NAME OF ATTENDING PHYSICIAN WITH PROFESSIONAL DESIGNATION (MD/DO)

12. Ohio Medicaid Provider Number, If Applicable — *7 Digits*	13. National Provider Identifier (NPI) — *10 Digits*

Signature Information

14. Date of Signature	15. Name of Person Signing
DATE OF TRANSPORT (XX/XX/XXXX)	PRINTED FULL NAME OF PERSON SIGNING

16. Signature and Professional Designation *(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)*

SIGNATURE OF PERSON SIGNING WITH PROFESSIONAL DESIGNATION (MD,DO,RN,CNS,PA,NP or DISCHARGE PLANNER)

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