Transfer Paperwork

Procedure for scheduling a transfer:

1. Completely fill out all forms included in this packet
   a. Page 2. Inter-facility Transport Worksheet – Please fill this form out as completely as possible in order to avoid delays in transport. If the sending facility needs to send a nurse or other personnel, Gold Cross will provide transportation back to their workplace.
   b. Page 3. Medical Necessity Certification Statement- This form must be completed entirely and signed by the attending physician, RN, LPN, social worker, case manager or discharge planner prior to ambulance transport. Describe patient physical condition and/or medical intervention that make ambulance transportation necessary. If this is a hospital to hospital transfer please write the procedure/specialist needed that is not available at the sending facility.
   c. Page 4. Interfacility transport requirements checklist- Please use this checklist to gather information for the transporting staff. Please do NOT fax this, give to the transport service upon arrival

2. Fax the following to 920.967.6077. (If you do not hear from Gold Cross within 20 minutes call to confirm receipt 920.727.3034)
   a. Page 2. Interfacility transport worksheet
   c. Copy of patients facesheet

*For Long Distance transfers (greater than 100 miles), notify us as soon as possible even if details are not confirmed so appropriate arrangements can be made

For Billing Questions:
Monday-Friday 0800-1630 call 920.727.3020

Dispatch: 920.727.3034 Dispatch Fax: 920.967.6077 Toll Free: 888.888.3838
Billing: 920.727.3020 Billing Fax: 920.727.3033
**Gold Cross Ambulance Service, Inc.**  
Fax - 920.967.6077  Dispatch - 920.727.3034  Toll Free - 888.888.3638  
**Inter-facility Transport Worksheet**  
Please complete this form and fax with a recent patient face sheet and Physician Certification Statement. If you are not contacted within 20 minutes of faxing this, please call Gold Cross Dispatch.

**CALL GOLD CROSS DISPATCH IMMEDIATELY IF:** CODE CARDIAC or CODE STEMI BEFORE STARTING PAPERWORK

**Please Note:** Patients who have Medical Assistance / Medicaid will require Pre Auth from Medical Transportation Management (MTM) before an ambulance is dispatched, please call (866) 307 1497 for prior authorization. (Not Applicable for ER or Emergent Transports)

**TRANSPORT PRIORITY TYPE**

Check One:
- **EMERGENT:** Patients requiring immediate surgical or procedural intervention at the receiving facility. These patients include but are not limited to STEMI, Acute Stroke, Trauma BlueAlert, AAA, or any patient at risk of severe deterioration if they remain at the sending hospital for an extended period of time.
- **URGENT:** Patients clinically stable, being sent out of an ER or ICU. These patients are at risk of deterioration if they remain at the sending hospital for an extended period of time.
- **NON-EMERGENT:** Patients being sent from a hospital floor to a nursing home, tertiary facility, or back home. These types of transfers are often pre-planned by the sending hospital.

**PLEASE PRINT LEGIBLY**

<table>
<thead>
<tr>
<th>Contact Person &amp; Phone Number</th>
<th>Date of Transport</th>
<th>Time of Transport (or) ASAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>Patient Date of Birth</td>
<td>Patient Weight</td>
</tr>
</tbody>
</table>

**Sending Facility (Please check appropriate box)**

- TC - Appleton  
- St Elizabeth  
- Mercy Medical Center  
- Calumet Medical Center  
- TC - Waupaca  
- Aurora - Oshkosh

ROOM NUMBER: __________  
Sending RN: __________  
Phone #: __________

**Receiving Facility (Please check appropriate box)**

- TC - Appleton  
- St Elizabeth  
- Froedtert - MKE  
- Mercy Medical Center  
- UW - Madison  
- Calumet Medical Center  
- CHOW - Milwaukee  
- CHOW - Neenah  
- TC - New London  
- TC - Waupaca  
- Aurora - Oshkosh

ROOM NUMBER: __________  
Receiving RN: __________  
Phone #: __________

**Medical Reason for Transport (Document more specifics on Medical Necessity Certification Statement)**

**Equipment Necessary**

- Oxygen: Nasal Cannula | NRB Mask | BiPAP | CPAP  
- IV x ___ Fluid/Drips  
- Ventilator  
- Cardiac Monitor YES NO (circle one)

**Precautions (MRSA, COVID-19 etc.)**

- Respiratory  
- Blood-borne  
- Other  
- COVID-19 Screening- PLEASE CIRCLE ONE BELOW  
  - NEGATIVE  
  - POSITIVE  
  - PUI  
  - UNTESTED ASYMPTOMATIC

4/29/2021
Gold Cross Ambulance Service, Inc.
Medical Necessity Certification Statement for Ambulance Services

SECTION 1 – DEMOGRAPHIC/GENERAL INFORMATION
Transport Date: ___________________________ Patient’s Name: ___________________________ Date of Birth: ___________________________
Origin: ___________________________ Destination: ___________________________

SECTION 2 – DESTINATION INFORMATION Medicare will only pay for an ambulance transport to the closest appropriate facility.
Specific Service/Procedure patient will receive at Destination Hospital: ___________________________

Is the above procedure available at Originating Hospital? □ YES (Patient responsible, non-covered by Medicare) □ NO

SECTION 3 – CLINICAL INFORMATION TO SUPPORT MEDICAL NECESSITY
Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. In general, Medicare does not cover routine transportation for a patient in nonemergency situations unless the patient’s condition warrants medical care/supervision during transport. Additionally, a patient must be transported to the closest “appropriate facility.” The fact that a more distant hospital is better equipped, either qualitatively or quantitatively, to care for a patient, does not warrant a finding that a closer institution does not have “appropriate facilities.”

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

Clinical Assessment: Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient’s condition:

In addition to completing the clinical assessment above, please check and describe any of the following conditions that apply:

□ Cardiac Monitoring required □ Airway Monitoring required □ Suctioning required (describe) □ IV meds/fluids required (describe) □ PRN meds (describe)
□ Requires oxygen – unable to self-administer (describe cognitive or physical impairment)
□ Patient is Comatose/Unconscious □ Morbid Obesity requires additional personnel/equipment: Weight and Height
□ Physical/Chemical restraints needed (explain)
□ Hemodynamic monitoring required (explain)
□ Orthopedic device (backboard, hab, pins, traction, brace, wedge, etc.) requiring special handling during transport (device)
□ Contractures requiring special positioning (describe)
□ Non-healed fractures (describe)
□ Decubitus ulcers/other wounds (describe stage and place)
□ Special handling due to Pain (describe where/cause)
□ Isolation/Infection precautions (describe)
□ Cognitive Impairment (describe)
□ Physical Impairment (describe)
□ Danger to self/others (explain)
□ Unable to tolerate seated position for duration of transport (explain)

Check all that apply: □ Unable to get up from bed without assistance □ Unable to ambulate □ Unable to sit in a chair or wheelchair

Patient Mental Status: □ Disoriented □ Person □ Place □ Time □ Psychological Disorder (specify) □ Mental Status Altered by medication

SECTION 4 – 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 and that other forms of transport are contraindicated. 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 I represent that I have personal knowledge of the patient’s condition at the time of transport.

PRINTED Name and Credentials of Healthcare Professional (MD, DO, RN, etc.) Signature of Physician* or Healthcare Professional Date Signed

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

□ PA □ NP □ CNS □ RN □ LPN □ Discharge Planner □ Case Manager □ Social Worker
Patient Name (or sticker): ___________________________ Room #: ___________________________
Receiving Facility Name: ___________________________
Receiving Nurse Name and Phone #: ___________________________

Inter-facility Transport Requirements Packet

*Please include the following information and give to your transport service upon arrival*
*Ascension ER may print SBAR which will include all needed information*
*ThedaCare ER may print ED encounter Summary which will include all needed information*

Complete the following and hand the packet to the EMS/Flight Crew upon their arrival:

- [ ] Updated Face Sheet
- [ ] Completed Physician Certification Statement (PCS) Worksheet
- [ ] Most recent H&P and/or ED Encounter
- [ ] Current lab results
- [ ] Trending vital signs
- [ ] Medication Administration Record (MAR) (*past 24 hours if inpatient*)
- [ ] Current EKG (*if applicable*)
- [ ] Radiological image(s) results (or disc) (*if applicable*)

Sending Nurse Name and Phone #: ___________________________
Nurse/Case Manager: ___________________________ Date: ___________________________

*Please Print Name*

Thank you for your time with completing these important documents/requirements. This packet will help expedite scene time and promote better quality of care for the patient.