Gold Cross
Ambulance Service, Inc.
Expert Care in a Heartbeat

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 work place.
    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**
    b. Page 3. **Medical Necessity Certification statement**
    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

Gold Cross Ambulance Service, Inc.

Fax - 920.967.6077 Dispatch - 920.727.3034 Toll Free - 888.888.3838

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) 907-1497 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 patient include but are not limited to STEMI, Acute Stroke, Trauma Blue/Alert, AAA, or aa 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 not at risk of deterioration if they remain at the sending hospital for an extended period of time.*

☐ **NON - EMERGENT**: *Patients being sent from the 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

Contact Person & Phone Number	Date of Transport	Time of Transport (or) ASAP
Patient Name	**Patient Date of Birth**	**Patient Weight**

Sending Facility (Please check appropriate box)

☐ TC - Appleton	☐ TC - Neenah	☐ TC - New London	☐ TC - Waupaca
☐ St Elizabeth	☐ Mercy Medical Center	☐ Calumet Medical Center	☐ Aurora - Oshkosh

ROOM NUMBER: _____ Sending RN:_____ Phone #:_____

Other: _____

Receiving Facility (Please check appropriate box)

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

ROOM NUMBER: _____ Receiving RN:_____ Phone #:_____

Other: _____

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

Equipment Necessary	Precautions (MRSA, COVID-19 etc.)
☐ Oxygen: Nasal Cannula | NRB Mask | BiPAP | CPAP	☐ Respiratory _____
☐ IV x_____ Fluid/Drips_____	☐ Blood-borne _____
☐ Ventilator _____	☐ Other _____
☐ Cardiac Monitor YES NO (circle one)	COVID-19 Screening- PLEASE CIRCLE ONE BELOW
☐ Other _____	NEGATIVE | POSITIVE | PUI | UNTESTED ASYMPTOMATIC

Gold Cross Ambulance Service, Inc.

Medical Necessity Certification Statement for Ambulance Services Ver 01/2021

SECTION I – 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, halo, 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 to ☐ 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): _____
Receiving Facility Name: _____ Room #: _____
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.