



Dispatch – 920.727.3034 Dispatch Fax – 920.967.6077 Toll Free – 888.888.3838
Billing – 920.727.3020 Billing Fax – 920.727.3033

Transfer Paperwork

Procedure for Scheduling a Non-Emergent Transfer

- Fill out all forms included in this packet.
- **If the patient has Medicaid/Medical Assistance, transportation must be arranged with MTM @ 866.907.1497 prior to transport. This does NOT apply to ER transports.**
- Fax a copy of the patient's hospital face sheet and packet contents to 920.967.6077.
- The Dispatch Center will make a concerted effort to contact you within 20 minutes to confirm receipt and time of transfer. If you have questions you may contact the Dispatch Center at 920.727.3034.
- If you know a long distance transfer (greater than 100 miles) may take place, notify us as soon as possible even if details are not confirmed so appropriate arrangements can be made for staffing.

Dispatch and Billing Department Phone/Fax Numbers

Questions related to billing can be answered Monday – Friday between the hours of 8:00a.m. – 6:30p.m. The billing department can be reached at 920.727.3020.

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.

Medical Necessity Certification Statement - (New for 2020)

This form must be completed and signed by the attending physician, registered nurse, licensed practical nurse, social worker, case manager, or discharge planner prior to ambulance transport. All signatures need to have a printed full name with credentials below the signature. Please describe thoroughly the patient's physical condition and/or medical intervention that make ambulance transportation necessary. If this is a hospital to hospital transfer please write the specific reason why the patient needs to be transferred to the receiving facility, what procedure/specialist is needed that the sending facility is unable to do.

Gold Cross Ambulance Service, Inc.

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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
PRIOR TO STARTING THIS PAPERWORK**

NOTE: If this patient has Medicaid/Medical Assistance, and being transported from the floor, the hospital must call MTM prior to transportation. (MTM - 866.907.1497) **This does NOT apply to ER transports.**

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	☐ Calumet Medical	☐ Aurora - Oshkosh

ROOM NUMBER: _____

Other: _____

Receiving Facility (Please check appropriate box)

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

ROOM NUMBER: _____

Other: _____

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

Equipment Necessary	Precautions (MRSA, etc.)
☐ Oxygen _____	☐ Respiratory _____
☐ IV x _____ Fluid/Drips _____	☐ Blood-borne _____
☐ Ventilator _____	☐ Other _____
☐ Cardiac Monitor YES NO (circle one)	
☐ Other _____	

Gold Cross Ambulance Service, Inc.
Medical Necessity Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____
Transport Date : _____ (Valid for round trips this date, or for scheduled repetitive trips for 60 days from date signed below.)
Origin: _____ Destination: _____
Is the Patient's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO
Closest appropriate facility? ☐ YES ☐ NO If no, why was the patient transported to another facility? _____
If hospital to hospital transfer, describe services needed at 2nd facility not available at 1st facility: _____
If hospice Pt, is this transport related to Pt's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than an ambulance is contraindicated by the patient's condition. **The following questions must be answered by the healthcare professional signing below for this form to be valid:**

- 1) 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:

- 2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
To be "bed confined" the patient must satisfy all three of the following criteria: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.
- 3) Can this patient safely be transported by car or wheelchair van (i.e., may safely sit during transport, without an attendant or monitoring?) ☐ Yes ☐ No
- 4) In addition to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*
☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement
☐ Danger to self/others ☐ IV meds/fluids required ☐ Patient is combative ☐ Need, or possible need, for restraints
☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self-administer
☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport
☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

☐ If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:

X _____

Signature of Physician* or Authorized Healthcare Professional

Date Signed

(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)

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

- | | | | |
|--|--|---|--|
| ☐ Physician Assistant | ☐ Clinical Nurse Specialist | ☐ Licensed Practical Nurse | ☐ Case Manager |
| ☐ Nurse Practitioner | ☐ Registered Nurse | ☐ Social Worker | ☐ Discharge Planner |