SAMARITAN E.M.S.
PAYEE #: 200472900 A

Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
Nursing Home/ Non-Emergency and Emergency Ambulance Transport

Date of Transport: _____

Patient Name: _____ Soonercare #_____

Origin: _____ Destination _____

1. What medical Condition exists that makes transport by ambulance necessary?

   _____

   _____

   _____

2. Please check any or all of the following that apply.

   _____ This patient is unconscious and/or unresponsive to voice/pain.

   _____ This patient requires administration of medical care and/or assessment transport. (Cardiac monitoring, Medication administration, O2, etc.) during

   _____ This patient must be transported on a stretcher and may not be transported in a sitting position such as a wheelchair.
   Please state why: _____

   _____

   _____ This patient has a contagious disease. Please state DX._____

   _____ This patient requires restraint and/or constant attendance due to confusion or combativeness.

   I certify to the best of my professional ability that this patient's condition warrants ambulance transportation and no lesser means is medically appropriate.

   Print Physician Name: _____

   Physician Signature: _____ Date: _____