TRIPLE-S ADVANTAGE

Certificate of Medical Necessity for Non-Emergency Ambulance Transportation

Section A: General Information (to be completed by the Ambulance Provider) | Service Date: _____/_____/_____

Patient Name:	Customer ID #:
Address:	Provider:
Telephone:	Provider Identification #:

Section B: Transfer information

☐ One way ☐ Round Trip

From:
- ☐ Home
- ☐ Hospital
- ☐ Physician Office
- ☐ Dialysis Center
- ☐ Other (please specify): _____

To:
- ☐ Home
- ☐ Hospital
- ☐ Physician Office
- ☐ Dialysis Center
- ☐ Other (please specify): _____

NOTE: This type of transportation is covered only in cases that the member's condition requires and justifies this type of transportation.

Section C: Medical Necessity Certificate (This part should be completed by the physician and/or service request provider)

Diagnosis Codes:

Treatment and findings:

Section D: Physician Attestation and Signature/Date

I, Dr. _____, with license number _____certify that the condition previously stated will compromise patient's health if other transportation method is provided.

Physicians Signature_____

Date: _____/_____/_____ NPI #:_____
Month Day Year

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