Lovington Fire Department

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Lovington, NM 88260
Office: 575.396.2359
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"Progressive and Professional"

TRANSFER JUSTIFICATION FORM

Patient: ______________________________________

Insurance Provider: ______________________________________

Insurance Number: ______________________________________

Date of Service: ______________________________________

From Nor Lea Hospital To: ______________________________

Requirements for Medicare, Medicaid, and private insurance have changed for hospital-to-hospital, hospital-to-residence (including long term care facilities) transports. Additional information is now required to justify medical necessity of the transfer. Please check the appropriate reason(s) the patient could not be treated at your facility. This paperwork must accompany all hospital-to-hospital and hospital-to-residence (including long term care facilities).

Please Note: Bed Confined Status must be accompanied by an additional reasoning (i.e. supplemental oxygen, cardiac monitor).

Condition of patient requiring medical transport:

☐ Unable to do medical testing at this facility due to ______________________________________.

☐ Travel by other means are contra-indicated due to ______________________________________.

☐ Patient transported to a higher level of care facility for the treatment of ______________________.

☐ Inadequate facilities to provide required care for treatment of ______________________________.

☐ Requires a specialist in ____________________ care and is not available in this facility.

☐ Other:____
____
____

Additional Comments: ____

______________________________ ______________________________

Printed Physician Name Signature of Physician Rev: 06/17