Ambulance Documentation Audit Form

Date of Service: ____________________ **Name of Patient:** ______________________________________

Payor: _____________________________________

Level of Service: BLS ALS ALS1 ALS2 Specialty Care Transport Paramedic ALS Intercept

Loaded Miles documented: _____________________________________

Code: _________________________________ **Correct Code (if appropriate):** _______________

Element	YES	NO	Comments
Patient's name, address, phone number, and health insurance claim number			
Date and time of transport			
Reason for transport (patient complaint/condition)			
Indication of emergency or non-emergency situation			
Name of person who ordered the transport			
Patient's or representative's signature (or why it was unobtainable)			
Patient assessment and chronological narrative of care/service rendered			
Patients related medical history if available			
Name and address of origin			
Name and address of destination			
Dispatch instructions documented			
Odometer reading at origin and destination			
Number of loaded miles			
Itemized list of specialized services and/or supplies			
Name of treating or receiving physician			
Names, titles, and signatures of ambulance personnel			
Provider's vehicle and license plate numbers			
Type of equipped vehicle (BLS or ALS)			
Round trip (documentation for each leg of the trip)			

Co-payment collected (20% for Medicare-Non-Indian Beneficiaries only)			
Oxygen included in ambulance service			
PCS signed by physician or appropriate other (Medicare Only)			
Medical Necessity indicated			

Auditor: ________________________________Date:_________________________

Notes:

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