PHYSICIAN CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORTATION

SECTION I – GENERAL INFORMATION

Patient's Name:_____ Medicare #:_____Date:_____

Origin:_____ Destination:_____

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 ambulance is contraindicated by the patient's condition.

To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; **AND** (2) *unable* to ambulate; **AND** (3) *unable* to sit in a chair or wheelchair **(Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)**

The following questions must be answered by the medical professional signing below for this form to be valid:

1) Is this patient "bed confined" as defined above? ___Yes ___No

2) Describe the PHYSICAL OR MENTAL CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition: _____

_____

_____

_____

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?) ___ 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 ___Moderate/severe pain on movement

___Danger to self/others ___ IV meds/fluids required ___Special handling/isolation required

___Third party assistance/attendant required to apply, administer or regulate oxygen enroute

___Restraints (physical or chemical) anticipated or used during transport

___Patient is confused, combative, lethargic, or comatose ___Cardiac/hemodynamic monitoring required enroute

___DVT requires elevation of a lower extremity

___Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport

___Unable to maintain erect sitting position in a chair for time needed to transport

___Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks

___Morbid obesity requires additional personnel/equipment to safely handle patient

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

_____ _____

Signature of Physician* or Healthcare Professional Date Signed

_____

Printed Name of Physician* or Healthcare Professional

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

Physician Assistant Clinical Nurse Specialist Registered Nurse Nurse Practitioner Discharge Planner