Physician Certification Statement for Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name:________________________ Date of Birth:__________ Insurance:_________________ Policy # : ______________________

Initial Transport Date:_________ Expiration Date (if Repetitive Transport) (Max 60 Days from Date Signed): ______

Origin Facility:_________________________

Destination:_____________________________ Services Needed at Destination:____

Is the Destination the nearest appropriate facility? ? Yes ? No

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR**, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

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 Medical 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:

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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 in medical records*

MOBILITY (In addition to above)

- € Unable to maintain erect sitting position without assistance due to moderate muscular weakness and deconditioning
- € Risk of falling off wheelchair or stretcher while in motion (not related to obesity)

- € MUSCULOSKELETAL
- € Incapacitating Osteoarthritis
- € Contractures that impair mobility while in motion (not related to obesity)
- € Muscular weakness and de-conditioned state that precludes significant physical activity
- € Non-healed fractures requiring ambulance
- € Orthopedic device required in transit
- € Amputation(s)

CARDIOVASCULAR

- € CVA with sequelae (late effect of CVA) that impair mobility and result in be confinement
- € DVT requires elevation of lower extremity

- € NEUROLOGICAL
- € Spinal Cord Injury – Paralysis
- € Progressive demyelinating disease
- € Moderate to severe pain on movement

WOUND

- € Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
- € Chronic wounds requiring immobilization

ATTENDANT REQUIRED DURING TRANSPORT

- € Morbid obesity requires additional personnel/ equipment to handle
- € Ambulance attendant required to administer, regulate, or adjust oxygen while in route
- € IV meds/fluids required
- € Cardiac/hemodynamic monitoring required while on route
- € DVT requires elevation of a lower extremity
- € Morbid obesity requires additional personnel/ equipment to safely handle patient Restraints (physical or chemical) anticipated or used during transport

MENTAL

- € Confused, combative, lethargic, comatose
- € Danger to self/others
- € Restraints (physical or chemical) anticipated or used during transport
- € Patient is confused, combative, lethargic, or comatose

OTHER

- € ____________________
- € ____________________
- € ____________________

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 or is based upon my personal familiarity with the patient's condition and I have reviewed this certification and determined that ambulance transportation is medically necessary for the reasons specified. Ambulance Transportation is hereby ordered.

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Signature of Physician* or Healthcare Professional

____ ______________________________________

Printed Name Date Signed

**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
- ☐ Nurse Practitioner
- ¨ Clinical Nurse Specialist
- ¨ Registered Nurse

☐ Discharge Planner