**Physician Certification Statement for Ambulance Services**

**SECTION I – GENERAL INFORMATION**

Patients Name: _____Date of Birth: _____Medicare#: _____
Transport Date: _____
Origin: _____Destination: _____

**SECTION II – MEDICAL NECESSITY QUESTIONNAIRE**

**Ambulance Transportation is medically necessary only if other means of transport are contraindicated or potentially harmful to the patient. The following questions must be answered by the signing medical professional for this form to be valid:**

1**) 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:**

_____

_____

2) **Can this patiently safely be transported in a wheelchair van (i.e., seated for the duration of the transport and without medical attendant?)** ☐ Yes ☐ No

3) ***In addition*** to completing question ***1*** and ***2*** above, please check any of the following conditions that apply. ***Supporting documentation for any boxes checked must be maintained in the patient's medical records***

☐ Contractures Location: _____
☐ Unhealed fractures ☐ Moderate/severe pain on movement
☐ IV meds/fluids required
☐ Third party assistance required to administer or regulate oxygen en route. ☐Requires suctioning en route
☐ Restraints (physical or chemical) anticipated or used during transport.
☐ Patient is combative ☐ Danger to self/others.
☐ Cardiac monitoring required en route.
☐ Unable to get out of bed without maximum assist of 2 or more people.
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport.
☐ Cannot support themselves safely while seated in a chair for time needed to transport.
☐ Unable to sit in a wheelchair due to pressure ulcers or wounds on buttocks or lower back. Stage 3 or 4 ulcer in any location.
**State location in section 1.**
☐ Severe dementia/confusion – trained monitoring required.
☐ Morbid obesity requiring 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 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.

Physicians NPI: _____

_____ _____ _____
Signature of Physician* or Healthcare Professional Print Name and title clearly Date Signed

***Forms 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 ☐Physician