Physician Certification Statement for Ambulance Services

SECTION I – GENERAL INFORMATION

Patients Name: _____ Date of Birth: _____ Medicare#: _____
Initial Transport Date: _____ Repetitive Transport Expiration Date (Max 60 Days from Date Signed): _____
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 ☐ Unhealed fractures ☐ Moderate/severe pain on movement
☐ IV meds/fluids required ☐ Special handling/isolation required
☐ Third party assistance required to administer, regulate or adjust oxygen en route. ☐Requires suctioning en route
☐ Restraints (physical or chemical) anticipated or used during transport.
☐ Patient is confused, combative, lethargic, or comatose. ☐ Danger to self/others.
☐ Cardiac/hemodynamic monitoring required en route.
☐ 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 wheelchair due to pressure ulcers or wounds on buttocks or lower back. **State location in section 1.**
☐ Stage 3 or 4 ulcer in any location. **State location in section 1.**
☐ 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

FACILITY NAME:

RN/MD ASSESSMENT FORM
SUPPORTING PCS DOCUMENTS
NARRATIVE

Date: _____

Patient Name:
Date of Birth:
Medicare #:

1. COGNITIVE STATE

- ☐ Alter-Mental Status _____
- ☐ Confusion _____
- ☐ Semicomatose _____

ABOVE CREATING BED CONFINEMENT STATUS UNSTEADY GAIT/FALL RISK

2. MEDICAL STATEMENT

- ☐ Requires Cardiac Monitoring _____
- ☐ Requires Intravenous Medication Drips _____
- ☐ Requires Oxygen and/or Suctioning Devices, Ventilator _____
- ☐ Stage 4 Decubiti Location: _____
- ☐ Morbid Obesity Approx. BMI _____
- ☐ Isolation Precautions _____

Patient Name:

Date:

3. MOBILITY LIMITATIONS

- ☐ Contractures _____
- ☐ Fracture Bones _____
- ☐ Orthopedic Devices: Braces, Collars, Halo, Backboard _____
- ☐ Physical or Chemical Restraints _____

4. PSYCHIATRIL LIMITATIONS

- ☐ Danger to Self/Others _____
- ☐ Combative Requiring as Above Physical or Chemical _____

Narrative:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Healthcare Professional

_____

Print Name and Title Clearly

_____

Date Signed

- ☐ Physician
- ☐ Physician Assistant
- ☐ Clinical Nurse Specialist
- ☐ Registered Nurse