Physician Certification Ambulance Statement

SECTION 1 – GENERAL INFORMATION

Patient's Name:_____DOB:_____Medicare #:_____Gender:_____
Transport Date:_____(Full) Physician Name:_____NPI:_____
Origin: _____ Destination: _____
_____ _____
_____ _____
Closest Appropriate Facility? ☐ Yes ☐ No If no, why is transport to more distant facility required? _____
_____
If hosp to hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____
If hospice pt, is this transport related to pt's terminal illness? ☐YES ☐NO Describe: _____

Section II – MEDICAL NECESSITY QUESTIONNAIRE

Describe the MEDICAL DIAGNOSIS (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported BY AMBULANCE: _____
_____
_____

CHECK **ALL** THAT APPLY TO YOUR PATIENT

- o The patient is "bed confined". To be "bed confined", the patient must be unable to get up from bed without assistance, unable to ambulate and unable to sit in a chair. NOTE: Bed confinement alone does not meet medical necessity for stretcher transport.
- o Special Handling/Positioning
  Fracture of the _____ Anatomical positioning supervised during transport _____
  Decubitus Ulcer: Location: _____ Stage _____ Anatomical positioning supervised during transport _____
  Location: _____ Stage _____
- o Unable to sit or hold self in place, even with seatbelts, due to (Circle all that apply) paralysis / contracture
  Location: _____ Anatomical positioning supervised during transport _____
  Location: _____

What position should EMT place patient in while in transport if unable to hold self-up? _____

- o Exhibiting signs of decreased level of consciousness due to _____
  EMT to Monitor for: _____ Intervention: _____
- o Patient requires monitoring/treatment **during** transport by an EMT to meet criteria: (check all applicable items below)

NOTE: EMT SKILLED NEED MUST BE PRESENT for ambulance transport

- o Ventilator dependent – monitor for: _____
  _____
- o IV Medications required en route: Monitor: _____
  _____
- o ECG Monitoring required en route – Diagnosis: _____
  _____
- o Oxygen Assistance required en route due to: _____
  _____
- o Suctioning/Airway Control required en route
- o Seizure prone/requires trained monitoring en route
- o Medication requires trained monitoring en route
- o Restraints: Circle all that apply: Chemical / Physical Due to:
  _____

- o One-on-One Supervision: Circle all that apply: Elopement Risk / Danger to Self or Others / Dementia or Alzheimer's with altered mental status
- o Isolation Precautions: Circle all that apply: Standard Precautions / Contact Precautions / Droplet Precautions / Airborne Precautions
  Due to: _____
- o Other (Please list reason and what needs monitored during the transport): _____
- o Can only be moved by stretcher due to _____

*****PLEASE USE THE BACK OF THIS FORM FOR ANY ADDITIONAL DETAILS OR NOTES NEEDED*****

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 and that other forms of transport are contraindicated. 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 I represent that I have personal knowledge of the patient's condition at the time of transport.

_____ Date Signed: _____
Signature of Physician* or Healthcare Professional
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____
Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending Physician, Nurse Practitioner, or Physician Assistant for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ M.D. or D.O. ☐ Physician Assistant ☐ Registered Nurse
☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Discharge Planner ***LPN MAY NOT SIGN***

Please fill out in detail Section II – Please sign, print, and note credentials in Section III. Please fax back to 855-498-5664 prior to scheduled non emergent transport.