Physician Certification Statement
Certificate of Medical Necessity for Ambulance Authorization

PATIENT LABEL

Patient Name: _____

DOB: _____/_____/_____ **SSN:** _____

☐ Medicare ☐ Medicaid ☐ Other: _____

Policy Number: _____**Date of Service:** _____/_____/_____

Transport Information

Transport from: _____ Transport To: _____

Is this a Round Trip? _____ Yes _____ No

Transport is for: _____ Diagnostic Test ____ Evaluation Test ____ Procedure ___ Discharge

____ Higher Level of Care _____ Other: _____

Describe type of treatment /service: _____

Is this the closest / appropriate facility? ____ Yes ____ No _____ Not Applicable

Is treatment available at origin facility? ____Yes ____No _____ Not Applicable

If patient is in Hospice care, is this transport related to patient's terminal illness? ____ Yes ____ No___ N/A

Dates: From: _____/_____/_____ To: _____/_____/_____

Describe the Medical Condition of the patient **AT THE TIME OF TRANSPORT** that requires patient to be transported in an ambulance and why transport by another means (car, wheelchair van) is contraindicated:

_____

_____

_____

Medical Necessity- ALL questions must be answered

1. **A bed confined** patient is one who is 1) unable to get up from bed without assistance; AND 2) unable to sit up in a chair or wheelchair; AND 3) unable to ambulate. Based on these criteria, at the time of transport is the patient bed confined? _____ Yes _____ No

2. **Medical services or monitoring** to be provided during transport: (____ Not Applicable)
   ____Oxygen Administration ____ Cardiac Monitoring ____ Airway Management ____IV Line (s)
   ___ Med Infusion Pump (s) ____ Ventilator/Suctioning ___ PRN Medication admin
   ___ Chemical Sedation ____ Other: _____

3. **Other** specific handling procedures or concerns that require ambulance include that the patient:

__ Is a fall risk, unsteady on his/her feet, and unable to move around without assistance

__ Is combative, poses a danger to self or others, and /or a flight risk

__ Requires restraints (either physical devices or chemical sedation)

_ Must remain immobile due to possible or confirmed fractures

_ Is contracted (circle): Upper Lower Fetal

__ Paralysis: ☐ Hemi ☐ Para ☐ Quad

__ Has orthopedic devices that require assistance and special handling

__ Is morbidly obese, non-ambulatory and requires additional staff and equipment to safely transport the patient

__ Requires special handling/isolation/infection precautions

__ Unable to be transported in a seated position, **Decubitus Ulcers:**

☐ Buttocks ☐ Coccyx ☐ Hip ☐ Sacrum

__ Other pertinent medical condition
_____
_____
_____

4. **At the time of transport**, patient was prescribed / order to be bed confined: ___ Yes ____ No

If YES, describe why: _____
_____

Form must be signed only by patient's attending physician for scheduled (with 24-hour advance notice), and / or 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.

_____ _____
Signature of Physician or Healthcare Professional Date Signed

_____ __Physician's Assistant __ Nurse Practioner __Discharge Planner
Printed Name of Healthcare Professional ____ MD __ Registered Nurse ____ Clinical Nurse Specialist

_____ _____
Authorizing Physician Printed Name NPI Number

By completing this form, 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.

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