SECTION L-GENERAL INFORMATION Patient' Name:	<u>Sample Physician Certification Statement for Non-Emergency Ambulance Services – Version 1.6</u>
Transport Date:	SECTION I - GENERAL INFORMATION
Origin:	Patient's Name: Date of Birth: Medicare #:
is the pt's stay covered under Medicare Part A (PE/DRG?) US Closest appropriate facility? UND Funo, why is transport to more distan facility required? Thom-hoop transfer, describe services needed at 2 ^{ad} facility on available at 1 ^{ad} facility: Thom-hoop transfer, describe services needed at 2 ^{ad} facility on available at 1 ^{ad} facility: Thom-hoop transfer, describe services needed at 2 ^{ad} facility on available at 1 ^{ad} facility: Thom photop transfer, describe services needed at 2 ^{ad} facility on available at 1 ^{ad} facility: Thom photop transfer, describe services needed at 2 ^{ad} facility on available at 1 ^{ad} facility: Thom photop transfer, describe the MDICAL CONDITION (physical and/or menta) of this patient from a condition such that transport by means be charged at a why transport by other means is containdicated by the patient's condition: 1	Transport Date: (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)
Cleasest appropriate facility: UN INO If no, why is transport on more distant facility required? If hosp-hoog transfer, describe services needed at 2 nd facility on available at 1 ^d facility:	Origin: Destination:
If hosp-hosp transfer, describe services needed at 2 nd facility to available at 1 ^d facility: If hosp-hosp transfer, describe services needed at 2 nd facility to available at 1 ^d facility: If hosp-hosp transfer, describe services needed at 2 nd facility to available at 1 ^d facility: If hosp-hosp transfer, describe services needed at 2 nd facility to available at 1 ^{df} facility: If hosp-hosp transfer, describe services needed at 2 nd facility to available at 1 ^{df} facility: If hosp-hosp transfer, describe services needed at 2 nd facility to available at 1 ^{df}	Is the pt's stay covered under Medicare Part A (PPS/DRG?) 🛛 YES 🖓 NO
If hospice pt, is this transport related to pt's terminal illness? INO Describe: Section L = MEDICAL CREESTIP QUESTIONNALEE Amount of the problem is medically necessary only if older means of transport are contraindicated or would be potentially harmful to the hospice for this form to be valid: Image: Section 1 and transport for the section 1 and transport are contraindicated or would be potentially harmful to the mathematic is contraindicated by the patient's condition. Image: Section 1 and transport for the section 1 and transport are contraindicated by the patient's condition. Image: Section 1 and transport for the section 1 and annual ance and why transport by other means is contraindicated by the patient's condition. Image: Section 1 and transport for the section 1 and transport are section 1 and transport without a medical attendant or monitoring? Image: Section 1 and transport 1 and transport 2 and transport 1	Closest appropriate facility? 🗆 YES 🛛 NO If no, why is transport to more distant facility required?
If hospice pt, is this transport related to pt's terminal illness? INO Describe: Section L = MEDICAL CREESTIP QUESTIONNALEE Amount of the problem is medically necessary only if older means of transport are contraindicated or would be potentially harmful to the hospice for this form to be valid: Image: Section 1 and transport for the section 1 and transport are contraindicated or would be potentially harmful to the mathematic is contraindicated by the patient's condition. Image: Section 1 and transport for the section 1 and transport are contraindicated by the patient's condition. Image: Section 1 and transport for the section 1 and annual ance and why transport by other means is contraindicated by the patient's condition. Image: Section 1 and transport for the section 1 and transport are section 1 and transport without a medical attendant or monitoring? Image: Section 1 and transport 1 and transport 2 and transport 1	
SECTION II – MEDICAL NECESSITY QUESTIONNAIRE Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient of the following questions must be answered by the medical profescional signing heless for this form to be valid: Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient are condition: Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient sc condition: Do to "bed confined" as defined below? Do to be "bed confined" the patient must satisfy all three of the following conditions: (1) <i>unable</i> to get up from bed without Assistance: AND (2) <i>unable</i> to ambulate: AND (3) <i>unable</i> to sit in a chair or wheelchair C and this patient safely be transported by car or wheelchair van (i.e., seated dyning transport, without a medical attendant or monitoring? D' In addition to completing questions 13 above, please check any of the following conditions that apply": "Note: supporting documentation for any baves checked must be maintained in the patient's corresting O transport self/other □ Nu meds/fluids required □ Patient is combative D' Trequires elevation of a lower extremity □ Medical attendant required □ Requires oxygen - unable to self administer D' Trequires elevation of a lower extremity □ Medical attendant required □ Requires oxygen - unable to self administer D' Trequires elevation of a lower extremity □ Medical attendant requires additional personnel/equipment to safely handle patient O orthoped	If hosp-hosp transfer, describe services needed at 2 nd facility not available at 1 st facility:
Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means of the than ambulance is contraindicated by the patient's condition. The following questions must be answered by the medical professional signing below for this form to be valid: 1. Describe the MEDICAL CONDITION (physical and/or mennial) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition: 2. Is this patient "bed confined" as defined below? 2. Is this patient must satisfy all three of the following conditions: (1) <i>unable</i> to get up from hed without Assistance. AND (2) <i>unable</i> to sumbulare: AND (3) <i>unable</i> to sit in a chair or wheelchair 2. Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring? 2. Is thad different to completing quessions 13 above, please check any of the following conditions that apply": 3. "Non healed fractures during during the constant of any bases checked must be maintained in the patient's condition or monitoring? 3. Traddiffient to completing quessions 13 above, please check any of the following conditions that apply": 3. "Non healed fractures during during transport during transp	If hospice pt, is this transport related to pt's terminal illness? 🗆 YES 🛛 NO Describe:
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To be "bed confined" the patient must satisfy all three of the following conditions: (1) <i>unable</i> to get up from bed without Assistance: AND (2) <i>unable</i> to ambulate; AND (3) <i>unable</i> to sit in a chair or wheelchair 3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring? a <i>the addition</i> to completing questions 1-3 above, please check any of the following conditions that apply":	1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:
Assistance: AND (2) unable to ambulate: AND (3) unable to sit in a chair or wheelchair 3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring? ''Yes No ''Note: supporting documentation for any boxes check any of the following conditions that apply*:	 2) Is this patient "bed confined" as defined below? □ Yes □ No To be "bed confined" the patient must satisfy all three of the following conditions: (1) <i>unable</i> to get up from bed without
9. 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 maintained in the patient's medical records Contractures Non-healed fractures Patient is contasce Moderate/severe pain on movement Danger to self/other IV meds/fluids required Patient is comatose Moderate/severe pain on movement Danger to self/other IV meds/fluids required Patient is comatose Moderate/severe pain on movement Danger to self/other IV meds/fluids required Patient is comatose Moderate/severe pain on movement Danger to self/other IV meds/fluids required Patient is comatose Moderate/severe pain on movement Danger to self/other IV meds/fluids required Need or possible need for restraints DVT requires elevation of a lower extremity Medical attendant requires Need to location of the second of the patient is another wounds Cardiac monitoring required enroute Morbid obesity requires additional personnel/equipment to safely handle patient Other (specify)	Assistance; AND (2) <i>unable</i> to ambulate; AND (3) <i>unable</i> to sit in a chair or wheelchair
*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records `*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records ``Danger to self/other IV meds/fluids required Patient is combative Need or possible need for restraints DVT requires elevation of a lower extremity Medical attendant required Requires oxygen - unable to self administer Cardiac monitoring required enroute Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds Cardiac monitoring required enroute Morbid obesity requires additional personnel/equipment to safely handle patient Other (specify) 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. Lunderstand that this information will be used by the Centers for Medicare and Medical Services (CMS) to support the determination of medical necessity for ambulance service's claim and that the institution with which 1 am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which 1 am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is not valid f	
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	*Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance

This is a sample only and does not constitute legal advice. User bears all responsibility for compliance with all applicable laws and regulations.