

LifeCare Emergency Medical Service

Physician Certification Statement for Ambulance Transport

This form must be completed for any transport from any facility, regardless of the patient's Medicare Status.

BAR CODE
EMS use only

Medicare requires under 42 CFR part 410.40(d) that ambulance transport obtain a *Certificate of Medical Necessity* signed by the patient's physician or representatives noted below for the provision of non-emergency transportation. This form **SHOULD BE COMPLETED PRIOR TO ANY NON-EMERGENCY TRANSPORT.**

SECTION 1 Patient Information

Patients Name _____ Transport Date _____ SSN _____
D.O.B. _____ Transport from _____ Rm _____ Destination _____ Rm _____
Physician Printed Name _____ Physician Office Fax # _____

SECTION 2 Medical Necessity (Check ALL that apply)

The Undersigned does hereby certify that the above named patient:

Patient is Bed Confined (to be bed-confined, all three conditions must be met) If Medicaid, a pre-authorization (PAN) is required: _____
 is unable to get up from bed without assistance, and _____
 is unable to ambulate, and _____ Hospitals call 1-800-540-0694
 is unable to sit in a chair or wheelchair (for duration of transport). _____ Nursing Homes Fax 1-512-514-4205
(Our TPI # 185244401)

In addition, the patient's condition is such that any other means of transportation (such as a stretcher service) is contraindicated and this patient:

- | | |
|---|--|
| <input type="checkbox"/> requires continuous oxygen & monitoring by staff | <input type="checkbox"/> weight exceeds wheelchair or stretcher van safety limit. Pt's approximate weight: _____ |
| <input type="checkbox"/> requires airway monitoring & suctioning | <input type="checkbox"/> requires restraints |
| <input type="checkbox"/> requires cardiac monitoring | <input type="checkbox"/> flight risk |
| <input type="checkbox"/> requires isolation precautions (VRE,MRSA,etc.) | <input type="checkbox"/> is seizure prone & requires trained monitoring |
| <input type="checkbox"/> is exhibiting decreased level of consciousness | <input type="checkbox"/> contractures to extremities Upper _____ Lower _____ |
| <input type="checkbox"/> is ventilator dependent | <input type="checkbox"/> is comatose & requires trained monitoring |
| <input type="checkbox"/> requires IV maintenance | <input type="checkbox"/> danger to self or others |
| <input type="checkbox"/> medicated and needs monitoring | <input type="checkbox"/> paralysis Hemi _____ Para _____ Quad _____ |
| <input type="checkbox"/> requires continuous oxygen & monitoring by staff | <input type="checkbox"/> frail, debilitated/risk of falling out of wheelchair explain below |
| <input type="checkbox"/> unrepaired or recent fracture/joint replacement and must remain immobile | |
| <input type="checkbox"/> other (explain) _____ | |

Description of why ambulance transport is required: _____

Hospital to Hospital Transfer-What service or equipment is needed or required for the patient that is available at the receiving facility that is not available at the transferring facility? _____

SECTION 3 Certification Signature

Based on the information available at this time, I believe it is in this patient's best interest they be transported to the designated facility by ambulance and should not be transported by other means. The patient's condition is such that transportation and observation by medically trained personnel is required. I certify that the above information is true and correct based on my evaluation, to the best of my knowledge and training.

Signature: _____ Physician RN Discharge Planner PA NP