Physician's Certification for Medical Necessity of Ambulance Service

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Transport Date: ____________________ Certification Expiration Date - max 60 days ____ /____ /____

Patient Name: ____

Transport To (facility name and address): ____

Transport from: ______________________________ Contact phone Number @ Destination ______________

Please check the appropriate medical condition(s) below, which would necessitate transport by ambulance according to CMS definition, and make all other means of transportation contraindicated based on patient health and safety.

CMS definition of confinement is; unable to get from bed without assistance; ambulate; and sit in a chair, including a wheelchair; does your patient meet any of these criteria's?

- ❒ If your patient does not meet bed-confined criteria as defined above, can this patient be safely transported by wheelchair van? Yes or No - If NO check the appropriate medical conditions listed below which would necessitate transport by ambulance.
- ❒ Is not wheelchair able (should not stand, pivot or ambulate and is unable to safely assist with moving themselves.
- ❒ Is comatose and requires trained monitoring.
- ❒ Requires oxygen and no portable oxygen is available.
- ❒ Requires physical restraints and/or the patient is chemically restrained medication given: __________ amount: __________ time:__________.
- ❒ Must remain immobile due to an unset fracture fracture site: ____.
- ❒ Is bed confined at time of transport reason: ____.
- ❒ Exhibits signs of decreased level of consciousness.
- ❒ Is seizure prone requiring trained monitoring.
- ❒ Is paralyzed and bed confined.
- ❒ Is suffering from decubitus ulcers and requires wound precautions.
- ❒ Requires airway monitoring and/or trained suctioning.
- ❒ Requires cardiac ECG monitoring.
- ❒ Requires isolation precautions (VRE, MRSA, etc.)
- ❒ There is no bed available at first facility
- ❒ Services not available at transferring facility: describe: ____.
- ❒ Burn unit required for treatment.
- ❒ The patient must be moved from a psychiatric to a medical hospital.
- ❒ The patient must be moved to a psychiatric ward under phycian petition.
- ❒ Special diagnostic studies are needed.
- ❒ Patient is ventilator dependant.
- ❒ Is able to tolerate a wheelchair but is inadvisable due to other condition indicated on this form.
- ❒ Other reason: ____.

Precautions/Isolation Necessary

❒ Universal ❒ Respiratory ❒ AFB

Patients Requiring Multiple Ambulance Transports

(ESRD Dialysis, Radiation, Chemo, etc.)

Describe why this patient's condition necessitates being transported by stretcher in an ambulance vs. being transported by wheelchair in a wheelchair accessible van?
Examples necessitating ambulance transport: history of stroke with residual paralysis and inability to sit up in wheelchair; pressure ulcers that prevent patient from sitting with out pain. Need for oxygen therapy and/or air-way suctioning; IV fluids running continuously; need for immobilizer inhibiting sitting position.

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I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services, Health Care Financing Administration or its agents, to support the determination of medical necessity for ambulance services.

Physician Printed Name:

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Authorized Signature:

____

Physician/UPIN Provider Number:

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Verbal Order Taken By:

____

Date Signed:

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