METRO AMBULANCE SERVICE:

PHYSICIAN CERTIFICATION STATEMENT FORAMBULANCE TRANSPORT

SECTION I - GENERAL INFORMATION

Version - August2014

Patient's Name:_____ Date of Birth:_____ Medicare #: _____

Medicaid # : _____ Transport Date:_____

Origin of Transport: _____ Destination: _____

SECTION II - MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR**, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered by the medical professional signing below for this form to be valid:

1) Is this patient "bed confined" as defined above? ☐ Yes ☐ No

2) Describe the Medical CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?)
☐ Yes ☐ No

4) ***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-Fetal ☐ Non-healed fractures ☐ Moderate/severe pain on movement
☐ Danger to self/others ☐ IV meds/fluids required ☐ Special handling/isolation required

☐ Restraints (verbal, physical or chemical) anticipated or used during transport

☐ Patient is confused, combative, lethargic, or comatose

☐ Cardiac/hemodynamic monitoring required enroute
☐ DVT requires elevation of a lower extremity
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling

☐ Unable to maintain erect sitting position in a chair for time needed to transport

☐ Unable to sit in a chair or wheelchair due to Grade III or greater decubitus ulcers on buttocks, or hips- Circle Location of Decubitus

☐ Morbid obesity requires additional personnel/equipment to safely handle patient- Patient Height/Weight? _____

☐ Other: _____

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 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.

I understand that this form is the property of Metro Ambulance Service, and will surrender the ***original form- signed and completed-*** at the time the patient is transported.

_____ _____

Signature of Physician* or Healthcare Professional Date Printed Name and Title

**Form must be signed only by patient's attending physician for Medicaid, scheduled, 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 (please check appropriate box below)*

☐ Physician ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

Metro
Ambulance Service

Non-Emergency Ambulance Service Request for Skilled Nursing Facilities: Version - 8/5/2014

Please complete and fax to Metro Ambulance Service @ 601-482-1316

Date of Transfer: _____ Repetitive Transport? ☐ Yes ☐ No

Patient's Name: _____ Changes Since Initial Evaluation? ☐ Yes ☐ No

Location/Room #: _____

Transport To: _____ Physical Address of Receiving Facility:

_____

Phone Number of Receiving Facility: _____

Printed Doctor's First & Last Name: _____

Pick Up Time: _____ Appointment Time: _____

This patient has:

☐ Medicare #: _____

☐ Medicaid #: _____

☐ Other: _____

☐ Magnolia, Windsor Medicare, United Healthcare, Chips? Policy #: _____

Patient DOB: _____

Responsible Party:

☐ Facility

☐ Patient

Patient SSN: _____

Brief History Summary:

_____

Medical Devices Required:

☐ IV Medications Required

☐ Oxygen

☐ ECG Monitoring

☐ Orthopedic Devices Required (Backboard, Halo, Use of Traction)

☐ Special Handling/Isolation

Transport Type Requested:

☐ Stretcher (Must have Medical Necessity Form Faxed with this Request)

☐ Wheelchair

Printed First & Last Name of Person Requesting Transfer: _____

Phone: _____ (If a response has not occurred to your request for service, a confirmation phone call should be made to Metro Ambulance Service @ 601-483-2260.)