

METRO AMBULANCE SERVICE:

PHYSICIAN CERTIFICATION STATEMENT FOR AMBULANCE TRANSPORT

SECTION I - GENERAL INFORMATION

Version - August 2014

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

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