Twin City Ambulance

Physician Certification Statement

Certificate of Medical Necessity

Date of Service: ______________________________

Patient Name ____

DOB ____

SSN ____

Please place patient registration label here, or complete by hand.

Transport Information

Transport From: ___________________________________ Transport To: __________________________________

Is this a Round Trip? ❑ Yes ❑ No

Transport is for: ❑ Diagnostic Test ❑Evaluation Test ❑ Procedure ❑ Discharge ❑Higher Level of Care ❑ Other

Describe type of treatment /service: ____

Is this the closest / appropriate facility? ❑ Yes ❑ No Is treatment available at origin facility? ❑ Yes ❑ No

If pt is in Hospice care, is this transport related to pt’s terminal illness? ❑ Yes ❑ No

Is the pt’s stay covered under Medicare Part A (PPS or DRG)? ❑ Yes ❑ No Dates: From:__________ To:__________

Describe the MEDICAL CONDITION of the patient AT THE TIME OF TRANSPORT that requires patient to be transport in an ambulance, and why transport by another means (car, wheelchair van) is contraindicated: ____________________________

____

Medical Necessity - ALL questions must be answered

1. A **bed confined** patient is one who is 1) unable to get up from bed without assistance; AND 2) unable to sit up in a chair or wheelchair; AND 3) unable to ambulate. Based on these criteria, at the time of transport is the patient bed confined?
   ❑ Yes ❑ No
2. Medical services or monitoring to be provided during transport: (❑ Not Applicable)
   ❑ Oxygen Administration ❑ Cardiac Monitoring ❑ Airway Management ❑ IV Line(s)
   ❑ Med Infusion Pump(s) ❑ Ventilator / Suctioning ❑ PRN Medication admin ❑ Chemical sedation
3. Other specific handling procedures or concerns that require ambulance include that the patient:

❑ Is a fall risk, unsteady on his/her feet, and unable to move around without assistance

❑ is combative, poses a danger to self or others, and/or a flight risk

❑ requires restraints (either physical devices or chemical sedation)

❑ must remain immobile due to possible or confirmed fractures

❑is contracted (circle): upper, lower, fetal

❑has orthopedic devices that require assistance and special handling

❑is morbidly obese, non-ambulatory and requires additional staff and equipment to safely transport the patient

❑requires special handling/isolation/infection precautions

❑has decubitus ulcers

❑Other:____________________________________

4. At the time of transport, patient was prescribed / order to be bed confined: ❑ Yes ❑ No
   If YES, describe why:____

By completing this form, 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.

____ ____

Signature of Physician* or Healthcare Professional Date Signed

____ ❑Physician’s Assistant ❑Nurse Practitioner ❑Clinical Nurse Specialist

Printed name of Healthcare Professional ❑Discharge Planner ❑Registered Nurse

**Form must be signed only by patient’s attending physician for scheduled (with 24-hour advance notice), and/or 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)*