Patriot Emergency Medical Services, Inc.

740.532.2222 **1. 866.888.5576** **304.523.2222**

PHYSICIAN CERTIFICATION STATEMENT

SECTION I - GENERAL INFORMATION

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

Effective Date: _____ Repetitive Transport Expiration Date: _____ Medicaid #: _____

Origin: (_____) _____
Zip Code

Destination: (_____) _____
Zip Code

SECTION II – MEDICAL NECESSITY QUESTIONAIRE

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** ☐Severe Trunk Weakness ☐ Muscle Deconditioning ☐ Vertigo ☐Orthostatic Hypotension ☐Duration and Terrain of Transport

☐ Restraint (☐chemical ☐physical) ☐Non-healed Fractures ☐Grade II or greater decubitus ulcers on buttocks ☐Significant unstable condition

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*

☐ Third party assistance/attendant required to apply, administer, regulate or adjust oxygen enroute ☐ Muscle wasting due to dis-use atrophy

☐ Cardiac/Hemodynamic monitoring during transport ☐ Special handling en route – Isolation ☐ Danger to self/others – Medical Supervision

☐ Moderate to severe pain with movement ☐ Elevation of lower extremity due to DVT ☐ Danger to self/others – Flight Risk

☐ Morbid obesity requires additional personnel/equipment to safely handle patient ☐ Bariatric stretcher required ☐ Contractures

☐ Special handling in transit due to orthopedic device (backboard, halo, use of traction etc.) ☐ IV medications/fluids during transport

☐ Severe muscular weakness and deconditioned state precludes any significant physical activity (including sitting upright during transport)

☐ Patient is confused, combative, lethargic and/or comatose ☐ Risk of falling off wheelchair/stretcher while in motion (not related to obesity)

☐ Frequent repositioning needed due to decubitus ulcers ☐ **THIS IS AN EMERGENCY TRANSFER/RESPONSE**

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.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____

_____ _____

Signature of Physician* or Healthcare Professional Printed Name Date

**Form must be signed only by patient's attending physician for 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 Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner

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