



p. 702-436-7911 / f. 702-207-0599

PHYSICIAN CERTIFICATION STATEMENT FOR NON-EMERGENCY AMBULANCE SERVICES

SECTION I – GENERAL INFORMATION

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

Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below)

Origin: _____ Destination: _____

Is the patient's stay covered under Medicare Part A (PPS/DRG?) YES NO

Is the patient being transported to the closest appropriate facility? YES NO If no, why is transport to a more distant facility required?

If hospital to hospital transfer, describe the services needed at the second facility not available at the first facility:

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the **MEDICAL CONDITION** (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition.

2) Is the patient "bed confined" as defined as below: YES NO

To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?) YES NO

4) In addition to completing sections 1-3 above, any of the following conditions that apply must be checked below*:

*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

- | | | |
|--|--|--|
| <input type="checkbox"/> Cardiac monitoring required enroute | <input type="checkbox"/> Morbid obesity requires additional personnel/equipment to safely handle patient | <input type="checkbox"/> Patient is combative |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Need or possible need for restraints | <input type="checkbox"/> Patient is confused |
| <input type="checkbox"/> Danger to self/other | <input type="checkbox"/> Non-healed fractures | <input type="checkbox"/> Requires oxygen – unable to self administer |
| <input type="checkbox"/> DVT requires elevation of a lower extremity | <input type="checkbox"/> Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport | <input type="checkbox"/> Special handling/isolation/infection control precautions required |
| <input type="checkbox"/> Hemodynamic monitoring required enroute | <input type="checkbox"/> Patient is comatose | <input type="checkbox"/> Unable to sit in a wheelchair due to decubitus ulcers or other wounds |
| <input type="checkbox"/> IV medications/fluids required | | <input type="checkbox"/> Unable to tolerate seated position for time needed to transport |
| <input type="checkbox"/> Medical attendant required | | |
| <input type="checkbox"/> Moderate/severe pain on movement | | |

Other (specify) _____

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 and that other forms of transport are contraindicated. 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 I represent 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

Date Signed

(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date)

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

*Form must be signed only by the patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check the appropriate box below):

- Registered Nurse Physician Discharge Planner Clinical Nurse Specialist Physician Assistant Nurse Practitioner