MURPHY
MEDICAL TRANSPORT

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# Physician Certification Statement / Certificate of Medical Necessity Form

## Section 1 - Beneficiary Information

Last Name: _____ First Name: _____ Middle Initial: _____
Sex: _____ D.O.B: _____/_____/_____ SSN: _____-_____-_____ Medicare #: _____
Diagnosis: _____
Date of Transportation: _____/_____/_____

## Section 2 - Transportation Information

Transport From: _____ Unit/Bed: _____ Discharge? Yes ☐ No ☐
Transport To: _____ Unit/Bed: _____ Admit? Yes ☐ No ☐

## Section 3 - Medical Necessity Questionnaire

Ambulance Transportation is medically necessary only if other means of transport are contraindicated based on patient safety and health. To meet this requirement, the patient must be "bed confined" …All three criteria below must be met to qualify for bed confinement:

1) Unable to ambulate Yes ☐ No ☐
2) Unable to get out of bed without assistance Yes ☐ No ☐
3) Unable to safely sit-up in a wheelchair Yes ☐ No ☐

Describe the MEDICAL CONDITION 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:
X_____

**PLEASE CHECK ALL THE MEDICAL CONDITIONS BELOW THAT APPLY:**

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose
☐ Danger to self/others ☐ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints
☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self-administer
☐ Specialty handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport
☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds
☐ Cardiac monitoring required enroute ☐ Moderate/severe pain on movement
☐ Morbid obesity requires additional personnel/equipment to safely handle patient; BMI _____
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Other Conditions not listed above (specify)
_____

## Section IV - 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. I am stating that I am a licensed Physician or Healthcare Professional, and I represent that I have personal knowledge of the patient's condition at the time of transport.

X_____ X_____

**Printed Name of Physician or Healthcare Professional** **Title**

X_____ X _____

**Signature of Physician or Healthcare Professional** **Date**