Sample Physician Certification Statement for Non-Emergency Ambulance Services – Version 1.6

SECTION I – GENERAL INFORMATION

Does NOT ALONE support medical necessity. Must have an accurate & complete PCR & be under direct care of a physician.

CANNOT be dated after actual transport date & for repetitive trips valid for only 60 days from beginning date.

Patient's Name: _____ Medicare #: _____

Transport Date: Beginning 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: _____

Make sure Origin & Destination MATCH PCR

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

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

_____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe: _____

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:

_____

_____

_____

All 3must be completed.

This section MUST match what is in the PCR.

If this information contradicts what is in the PCR, then crew should review PCR for accuracy. If errors exist in PCR, amendments can only be made by PCR writer. Paper PCR amendments need initialed and dated by writer.

PCS amendments can only by amended/initialed/dated by PCS signer.

Billers cannot advise what needs changed in order for it to pay - only explain where the information contradicts and ask if any corrections need made.

2) Is this patient "bed confined" as defined below?
To be "bed confined" the patient must satisfy all three of the
Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to

3) Can this patient safely be transported by car or wheelchair van (i.

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 ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement

☐ Danger to self/other ☐ 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

☐ Special 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 ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ 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***:

Not valid unless signed AND printed 'legible' signature provided.

For **scheduled, repetitive** must be signed prior to transport and not valid for more than 60 days after signature date. For **scheduled non-repetitive or unscheduled**, signature must be dated no later than 48 hours after transport..

_____ _____

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).

DON'T forget Physician Credentials (MD, DO)

_____

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

**Form must be signed only by 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 (pleas*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse

☐ Nurse Practitioner ☐ Discharge Planner

NO EXCEPTIONS. Scheduled Repetitive trips must have Attending Physician (MD, DO) only signature. If not Scheduled Repetitive, can be signed by one of the following, and may be noted above by name instead of checked.