Washington Fire Department

200 N Wilmor Rd Washington, IL 61571 • Phone: (309) 840-4503 • Fax: (309) 444-9532

Physician Certification Statement for Non-Emergency Ambulance Services

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| Section I – General Information |
| Patient’s Name: \_Click or tap here to enter text.\_ Date of Birth: \_Click or tap here to enter text.\_Transport Date: \_ Click or tap here to enter text.\_  Medicare #: \_ Click or tap here to enter text. \_ Medicaid #: \_ Click or tap here to enter text. \_  Origin: \_ Click or tap here to enter text. \_ Destination: \_ Click or tap here to enter text. \_  Is the pt’s stay covered under Medicare Part A (PPS/DRG?) YES NO  Is the destination within the same locality as the origin or to the closest appropriate facility? YES NO If neither, why is transport to a more distant facility necessary? \_ Click or tap here to enter text. \_  Is hospital-hospital transfer, describe services needed at 2nd facility not available at first facility: \_ Click or tap here to enter text. \_  If hospice pt, is this transport related to pt’s terminal illness? YES NO |
| 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:   \_ Click or tap here to enter text. \_   1. Is this patient “bed confined” as defined 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   1. Can this patient be safely transported by car or van (i.e., seated during transport, without a medical attendant or monitoring?) YES NO 2. ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply\*:  |  |  |  | | --- | --- | --- | | 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 |   \*Note: supporting documentations for any boxes checked must be maintained in the patient’s medical reports  Other \_ Click or tap here to enter text. \_ |
| 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 424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:***   |  |  | | --- | --- | | \_ Click or tap here to enter text. \_A  Signature of Physician\* or Healthcare Professional | \_ Click or tap here to enter text. \_ A  Date Signed (for scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date |   \_ Click or tap here to enter text. \_  ***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 transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | ***Medicare:*** (Only those listed may complete form)   |  |  | | --- | --- | | Physician Assistant  Nurse Practitioner  Registered Nurse | Clinical Nurse Specialist  Discharge Planner | | ***Medicaid:*** (any of the previous plus those listed below)   |  |  |  | | --- | --- | --- | | Physician Assistant  Nurse Practitioner  Registered Nurse | Clinical Nurse Specialist  Discharge Planner  Licensed Practical Nurse | Case Worker | | |