



# 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

### Section I – General Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Transport Date: \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Origin: \_\_\_\_\_ Destination: \_\_\_\_\_

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? \_\_\_\_\_

Is hospital-hospital transfer, describe services needed at 2<sup>nd</sup> facility not available at first facility: \_\_\_\_\_

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: \_\_\_\_\_

2) 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

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

4) **In addition** to completing questions 1-3 above, please check any of the following conditions that apply\*:

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

\*Note: supporting documentations for any boxes checked must be maintained in the patient's medical reports

Other \_\_\_\_\_

### 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:**

\_\_\_\_\_  
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 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)

- |  |  |
|--|--|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Nurse Practitioner  | <input type="checkbox"/> Discharge Planner         |
| <input type="checkbox"/> Registered Nurse    |  |

**Medicaid:** (any of the previous plus those listed below)

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Case Worker |
| <input type="checkbox"/> Nurse Practitioner  | <input type="checkbox"/> Discharge Planner         |                                      |
| <input type="checkbox"/> Registered Nurse    | <input type="checkbox"/> Licensed Practical Nurse  |                                      |