

**MEDICARE**

**Physician Certification Statement For Ambulance Transportation**

*(To be completed by hospital personnel / physician and original copy given to transport paramedic)*

**SECTION 1 – Patient Information**

Patient's Name: \_\_\_\_\_ Transport Date: \_\_\_\_\_  
Medicare #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Transport from: \_\_\_\_\_ Transport to: \_\_\_\_\_  
Physician's Printed Name: \_\_\_\_\_ Physician's Office Fax #: \_\_\_\_\_

**SECTION 2 – Medical Necessity**

**Statement of Bed Confinement**

The Undersigned does hereby certify that the above named patient is unable to get up from bed without assistance, is unable to ambulate, and is unable to sit in a chair or wheelchair (for duration of transport). The patient's medical condition is such that other means of transportation is contraindicated.

Patient is bed-confined secondary to:

**And/Or**

**This patient's medical condition is such that other means of transportation is contraindicated due to** *(please check all of the following that apply):*

- |  |  |
|--|--|
| <input type="checkbox"/> requires continuous oxygen & monitoring by trained staff  | <input type="checkbox"/> has decubitus ulcers & requires wound precautions                   |
| <input type="checkbox"/> requires airway monitoring or suctioning                  | <input type="checkbox"/> requires isolation precautions (VRE, MRSA, etc.)                    |
| <input type="checkbox"/> patient is ventilator dependent                           | <input type="checkbox"/> requires restraints   |
| <input type="checkbox"/> requires cardiac monitoring                               | <input type="checkbox"/> weight limit exceeds wheelchair or stretcher van safety limitations |
| <input type="checkbox"/> requires IV maintenance                                   | <input type="checkbox"/> comatose & requires trained monitoring                              |
| <input type="checkbox"/> is exhibiting signs of a decreased level of consciousness |  |
| <input type="checkbox"/> is seizure prone & requires trained monitoring            |  |
| <input type="checkbox"/> Other (Explain) _____                                     |  |

\*\*\* Or \*\*\*

**The patient does not meet any of the above criteria of medical necessity for ambulance transportation.**

**SECTION 3 – Authorizing Signature**

\_\_\_\_\_  
Authorizing Signature

\_\_\_\_\_  
Date Signed

- |  |   |                                      |   |
|--|---|--------------------------------------|---|
| <input type="checkbox"/> Attending Physician | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> R.N.        | <input type="checkbox"/> Case Mgr/Social Worker |
| <input type="checkbox"/> P.A.                | <input type="checkbox"/> C.N.S              | <input type="checkbox"/> D/C Planner | <b>* LPN's are not authorized to sign</b>       |

Medicare requires under 42 CFR Part 410.40(d) that ambulance providers obtain a **Certificate of Medical Necessity** signed by the patient's physician for the provision of non-emergency transportation. This form has been designed to assist the physician, the facility, the Medicare Beneficiary and the ambulance provider to determine if Medical Necessity has been met. I certify that our institution has furnished care or other services to the above named patient. I hereby sign on the patient's behalf. This signature is not an acceptance of financial responsibility for the patient. Please complete all sections of this form and have the patient's physician sign and date the form. The form should be completed prior to the ambulance crew transporting the patient. If the form cannot be completed when the transportation services are provided, please fax the form to (727) 582-2223 within forty-eight (48) hours of transport.

Sunstar Incident # \_\_\_\_\_

PR # \_\_\_\_\_

To be completed by ambulance Paramedic

Revised 01/08/08