SUPERIOR AMBULANCE SERVICE

Physicians Certification Statement For Ambulance Transportation

DR:

From:

To:

HEALTHCARE PROFESSIONAL: PLEASE COMPLETE THIS FORM AND RETURN TO: . FAX 630-903-2836, Email . IF YOU HAVE ANY QUESTIONS PLEASE CALL .

Section 1 - Beneficiary Information

Name:	Date of Service:	Run #:	DOB:
Patient's SSN:	Medicare No:	RIN:	

Is this a round trip transport? [X] **Yes** [X] **No**

If Hospital to Hospital, What services were not available? [ ] Mental Health Services [ ] No inpatient Beds Available [ ] Physician or Patient Preference

[ ] Specialized Cardiac Care _____ [ ] Rehabilitation _____

[ ] Surgery (specify) _____ [ ] Physician Specialist _____

Is this destination the closest appropriate provider/facility? [ ] **Yes** [ ] **No** If no, why is transport beyond the closest appropriate provider/facility? _____

Section 2 - Medical Necessity Information *(to be completed by physician or healthcare professional)*

A patient is bed confined if he/she is unable to get up from bed without assistance, unable to ambulate & unable to sit in a chair.
Ref. 42 CFR 410.40(d)(1)

Based on the above Definition, is the patient **bed confined?**

[ ] Yes (List medical condition) _____

[ ] **No (Patient is not bed confined, Complete the next section below listing the reason an ambulance is needed)**

[ ] **Danger** to self/others due to: _____

[ ] **Restraints** (physical or chemical) anticipated during transport due to: _____

[ ] **Combative** / Unpredictable due to: _____

[ ] Dementia/Alzheimers with severe altered mental status at time of transport

[ ] **Pain** upon movement (moderate to Severe) due to: _____

[ ] Unable to maintain **safe sitting** position for length of transport due to: _____

[ ] **Immobilization** required due to: _____

[ ] Non-healed **fractures**, specify site _____

[ ] **Contractures**, specify site _____

[ ] **Isolation** precautions due to _____

[ ] **Decubitus Ulcers** [ ] Buttocks [ ] Coccyx [ ] Hip [ ] Other (Specify) _____ Stage [ ] 2 [ ] 3 [ ] 4

[ ] Severe **weakness:** [ ] frail / delibitated [ ] terminal disease process due to: _____

[ ] Requires advanced **airway** monitoring: [ ] suctioning [ ] ventilator

[ ] Third party assistance/attendant required to apply, administer or regulate or adjust **oxygen** enroute

[ ] **Morbid obesity** requires additional personnel/equipment to safely handle patient _____ lbs / kg _____ Height

[ ] Other: _____

[ ] **Elopement** precautions due to: _____

[ ] **EKG** monitoring required

[ ] **IV** required or maintained

[ ] **Paralysis** (see options below)

[ ] Hemiplegia

[ ] Hemiparalysis

[ ] Quadriplegic

[ ] DVT requires elevation of lower extremity

Section 3 - Authorization

I certify that the information contained in Section 2 above represents an accurate assessment of the beneficiary's medical condition(s) and that ambulance transporation is medically necessary. I also certify that our institution has furnished care of other services to the above named patient in the past. In the event that is unable to obtain the signature of the patient due to physical or mental incapability or another authorized representative, I hereby sign on the patients' behalf for purposes of satisfying the patient signature requirement, pursuant to 42.C.F.R.424.36(b)(4).

Physician or Healthcare Professional Signature: X _____ **Date:** ____/____/____

Print the name and the credentials of the Healthcare Professional signing _____

[ ] **Physician** [ ] **Clinical Nurse Specialist** [ ] **Registered Nurse** [ ] **Social Worker**

[ ] **Nurse Practioner** [ ] **Discharge Planner** [ ] **Physician Assistant** [ ] **LPN**