SUPERIOR AMBULANCE SERVICE

Physicians Certification Statement For Ambulance Transportation

Sending Facility: Room #:

Receiving Facility Room #: Time of Transfer: ☐am ☐pm

HEALTHCARE PROFESSIONAL: PLEASE COMPLETE THIS FORM AND RETURN TO: SUPERIOR AIR-GROUND AMBULANCE SERVICE, INC. FAX 630-903-2836. IF YOU HAVE ANY QUESTIONS PLEASE CALL 630-903-2331.

Section 1 - Beneficiary Information

Name:	Date of Service:	Run #:	DOB:
Patient's SSN:	Medicare #:	RIN:	

Is this a round trip transport? ☐ Yes ☐ 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 _____

☐ Cardiac Cath ☐ Other (specify) _____

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 listing the reason, if 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 the 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 _____

☐ Elopement precautions due to: _____

☐ EKG monitoring required

☐ IV required or maintained

☐ Paralysis (see options below)

- ☐ Hemiplegia
- ☐ Hemiparalysis
- ☐ Quadriplegic

☐ DVT requires elevation of lower extremity

☐ Decubitus Ulcers ☐ Buttocks ☐ Coccyx ☐ Hip ☐ Other (specify) _____ Stage ☐ 2 ☐ 3 ☐ 4

☐ Severe weakness: ☐ Frail / debilitated ☐ Terminal disease process due to: _____

☐ Requires advanced airway monitoring: ☐ Suctioning ☐ Ventilator

☐ Third party assistance/attendant required to apply, administer or requlate or adjust oxygen enroute

☐ Morbid obesity requires additional personnel/equipment to safely handle patient _____ lbs / kg _____ height

☐ Other: _____

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 transportation is medically necessary. I also certify that our institution has furnished care or other services to the above named patient in the past. In the event that Superior Air-Ground Ambulance Service, Inc. 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 credentials of the Healthcare Professional signing _____

☐ **Physician** ☐ **Clinical Nurse Specialist** ☐ **Registered Nurse**

☐ **Nurse Practitioner** ☐ **Discharge Planner** ☐ **Physician Assistant**

SUP19-005