Physician Certification Statement for Ambulance Transportation

Section I – Patient Information **Date(s) of Service:**

Last Name: ____ **____ / ____ /_______**

First Name: ____

Patient Transported from: ____

Patient Transported to: ____

Section II – Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. **Supporting documentation for any boxes checked must be maintained in the patient's medical records.**

Check all that apply:

- ☐ Bed Confined ***All three below must be met to qualify for bed confinement**
  - o Unable to ambulate*
  - o Unable to get out of bed without assistance*
  - o Unable to safely sit up in a wheelchair*
- ☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning.
- ☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medications/fluids required during transport
- ☐ Cardiac/Hemodynamic monitoring required during transport
- ☐ Special handling en route – Isolation
- ☐ Contractures
- ☐ Non-healing fractures
- ☐ Moderate to severe pain on movement
- ☐ DVT requires elevation of lower extremity
- ☐ Morbid Obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc) requiring special handling in transit
- ☐ Severe Muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Restraints (Physical or Chemical) anticipated or used during transport
- ☐ Danger to self or others – monitoring
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Danger to self or others – seclusion (flight risk)
- ☐ Confused, combative, lethargic, comatose

Section III –Authorization

I certify that the information above represents an accurate assessment of the patient's medical condition on the date of service.

______________________________	______________________________	________________
(Physician, RN or Other Signature)	**(Physician, RN or Other Name Printed)**	**Date**

This authorization must be completed and signed. For scheduled repetitive transports, the authorization **MUST** be signed by the attending physician. For unscheduled or scheduled non-repetitive transports the authorization may be signed by the attending physician, physician assistant, clinical nurse, nurse practitioner, registered nurse or discharge planner (employed by the facility where the beneficiary is being transported) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.