BEACON
HEALTH SYSTEM

Physician Certification Statement for Non-Emergency Ambulance Services

SECTION 1 — GENERAL INFORMATION

Patient's Name: ______________________ Date of Birth: ______________ Medicare #: ______________

Transport Date: ______________ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin: ______________________ Destination: ______________________

Is the patient's stay covered under Medicare Part A (PPS/DRG?) ❑ Yes ❑ No

Closest appropriate facility? ❑ Yes ❑ No If no, why is transport to more distant facility required? ______________________

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: ______________________

If hospice pt, is this transport related to pt's terminal illness? ❑ Yes ❑ No Describe: ______________________

SECTION 2 — 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 <u>by the medical professional signing below</u> 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 safely be transported by car or wheelchair 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*:
   **Note: Supporting documentation for any boxes checked must be maintained in the patient's medical record.*

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

SECTION 3 — SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of the 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 §424.38(b)(4). In accordance with 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/Time Signed ______________________
(For scheduled repetitive transport, this form not valid for transports performed more than 60 days after this date)

Printed Name and Credentials of Physicians or Healthcare Professionals (MD, DO, RN, etc.) ______________________

**Form must be signed only by patient's Attending Physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the Attending Physician, any of the following may sign (Please check appropriate box below.):*

❑ **Physician Assistant** ❑ **Nurse Practitioner** ❑ **Clinical Nurse Specialist** ❑ **Registered Nurse** ❑ **Discharge Planner**

576685