



Physicians Certification Statement

This is a HCFA Document for Medicare Ambulance Transportation

• SECTION 1 - PATIENT INFORMATION

Name _____ Last First MI	D.O.B. _____
Medicare Number _____	Sex: ___ SSN: _____

• SECTION 2 - TRANSPORT INFORMATION

Certification Date(s): _____
Origination Facility Type/Name (MOD1): _____
Destination Facility Type/Name (MOD2): _____

• SECTION 3A- MEDICAL NECESSITY INFORMATION

The Medicare Definition of Medical Necessity for non-emergency ambulance transportation is:
The inability to get up from bed without assistance and the inability to ambulate and the inability to sit in a chair or wheelchair.
Please document patient conditions **Mark the appropriate box (es):**

1. The minimum safe level of transportation was or is:
 Wheelchair Transport (Skip to section 4)
 Ambulance (Go to item 2.)

2. **Why Ambulance:** Other means of transportation are contraindicated based on the following conditions requiring ambulance transport:

<input type="checkbox"/> <u>Requires medical supervision during transport (explain below)</u>	<input type="checkbox"/> <u>Requires EKG Monitoring</u>
<input type="checkbox"/> <u>Is comatose or obtunded, requires trained monitoring</u>	<input type="checkbox"/> <u>Requires continous oxygen</u> Not self-administered
<input type="checkbox"/> <u>May tolerate a wheelchair but is medically unstable (explain below)</u>	<input type="checkbox"/> <u>Is ventilator dependent</u>
<input type="checkbox"/> <u>Cannot safely support themselves in a wheelchair</u>	<input type="checkbox"/> <u>Requires airway monitoring</u>
<input type="checkbox"/> <u>Is on hip precautions & cannot safely sit</u>	<input type="checkbox"/> <u>Other (explain below)</u>
<input type="checkbox"/> <u>Psych (explain safety issue below)</u>	

• SECTION 3B - MEDICAL NECESSITY INFORMATION

Explain conditions, not necessarily a diagnosis, which necessitates ambulance transport: _____ _____
What specialized service is to be provided at the receiving facility that is not available at the sending facility? _____ _____
What conditions contraindicate travel by wheelchair van? _____ _____

• SECTION 4 - SIGNATURE OF PHYSICIAN AND/OR RN

Print Physician name: _____	Print RN Name: _____
UPIN: _____	
_____ PHYSICIAN SIGNATURE	_____ RN SIGNATURE
_____ DATE	_____ DATE