Physician Certification Statement For Ambulance Transportation

Medicare Part B pays for ambulance transportation only if other means of transportation would endanger the beneficiary's health (42 CFR Part 410.4(d)(1)). This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance company to determine if Medical Necessity has been met. Please complete all sections of this form and have the patient's physician sign the form prior to transport.
The completed form should be sent to Ridge Ambulance Service via fax at (630) 859-2737. If you have any questions call (630) 898-2117.

Section 1 - Beneficiary Information

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

In this a round trip transport? ❑ Yes ❑ No

Hospital to Hospital Transports

Equipment not available
- ❑ MRI not available
- ❑ MRI is full
- ❑ CAT Scanner not available
- ❑ Other: ________________

Procedure not available
- ❑ Angiogram
- ❑ Cardiac Cath
- ❑ Dialysis
- ❑ Other: ________________
- ❑ Neurosurgery
- ❑ Organ Transplant
- ❑ Radiation Therapy

Special care not available
- ❑ Psychiatric Unit
- ❑ ICU bed
- ❑ Trauma Center

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 and unable to sit in a chair.
Ref. 42 CFR 410.4(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
- ❑ Restraints (physical or chemical) anticipated during transport
- ❑ Combative / Unpredictable
- ❑ Severe dementia / potentially combative
- ❑ Pain upon movement (moderate to severe)
- ❑ Unable to maintain safe sitting position for length of transport
- ❑ Immobilization required (Backboard, Halo)
- ❑ Non-healed fractures, specify site ________________________________
- ❑ Contractures, specify site________________________________
- ❑ Isolation precautions due to________________________________
- ❑ Decubitus Ulcers ❑ Buttocks ❑ Coccyx ❑ Hip ❑ Other (specify) ________________ Stage ________________
- ❑ Severe weakness: ________ frail / debilitated ________ terminal disease process
- ❑ Requires advanced airway monitoring: ________ suctioning ________ ventilator
- ❑ Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute
- ❑ Morbid obesity requires addition personnel/equipment to safely handle patient ________ lbs / kg
- ❑ Other: ________________________________

- ❑ Elopement precautions
- ❑ EKG monitoring required
- ❑ IV required or maintained
- ❑ Paralysis (see options below)
  - ❑ Hemiplegia
  - ❑ Hemiparalysis
  - ❑ Paraplegia
  - ❑ Quadriplegic

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 of other services to the above named patient in the past. In the event that Ridge Ambulance Service, Inc. is unable to obtain the signature of the patient 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,424,35(b)(4).

This form may be signed by any of the following if the attending Physician is unable to sign. *Form must be signed only by patient's attending Physician, Physician assistant, or nurse practitioner.

Physician or Healthcare Professional Signature ✘ ________________________________ Date: ____ / ____ / ____

Print the name of the Healthcare Professional signing ________________________________

Form must be signed only by patient's attending physician for scheduled, repetitive transports and is valid for 60 days after date signed.
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
- ❑ Nurse Practitioner
- ❑ Clinical Nurse Specialist
- ❑ Discharge Nurse
- ❑ Registered Nurse
- ❑ Physician Assistant