

(612) 638-4970 Fax



1 (800) 328-1377

AMBULANCE PCS

612-378-5465

Physician Certification Statement for Ambulance Transportation

Section 1 – Beneficiary Information

Patient Name	Diagnosis
Date of Transport	Medicare / Medicaid #
Sending Facility	Destination

Section 2 – Medical Necessity Information for NON EMERGENCY TRANSPORTATION ONLY

Can the patient be transported by car, taxi, bus or wheelchair van? Yes No

If YES, the patient does not meet criteria for stretcher transportation

Is the beneficiary able to get up from bed without assistance? Yes No

Is the beneficiary able to ambulate? Yes No

Is the beneficiary able to sit in a chair or wheelchair? Yes No

Describe the **PHYSICAL** or **MENTAL CONDITION** of the patient **AT THE TIME OF AMBULANCE TRANSPORTATION** that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition

Section 3 – Hospital to Hospital Transfers

Is the patient being transferred to a higher level of care? Yes No

List the facilities required/available at destination facility not available at the originating facility

Burn Care Trauma Care Cardiac Care Critical Care Pediatric Care Other _____

Was the patient transported to the **CLOSEST APPROPRIATE FACILITY**? Yes No

If NO, describe why the patient had to be transported to the further facility.

Please notify the patient/family that they may be financially responsible for the difference in mileage.

Section 4 – Air Ambulance Transportation

Please select below the condition(s) requiring transportation by air ambulance

Intracranial bleeding requiring neurosurgical intervention Cardiogenic Shock

Burns requiring treatment in a burn center Conditions requiring treatment in a Hyperbaric Oxygen Unit

Multiple Severe Injuries Life Threatening Trauma

Other (please explain)

Patient has a medical condition that requires immediate and rapid transport due to the nature and/or severity of their illness / injury, and transportation by ground ambulance in excess of 30 minutes would endanger the patient's life or health

Section 5 – Physician Certification

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. 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.

Signature of Physician* or Healthcare Professional	Date	Print Name and Credentials (MD, RN, etc.)
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*** Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (please check the appropriate box below)**

Physician Assistant Clinical Nurse Specialist Registered Nurse Nurse Practitioner Discharge Planner