

(612) 638-4970 Fax



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# 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*

<input type="checkbox"/> Intracranial bleeding requiring neurosurgical intervention	<input type="checkbox"/> Cardiogenic Shock
<input type="checkbox"/> Burns requiring treatment in a burn center	<input type="checkbox"/> Conditions requiring treatment in a Hyperbaric Oxygen Unit
<input type="checkbox"/> Multiple Severe Injuries	<input type="checkbox"/> Life Threatening Trauma
<input type="checkbox"/> 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.**

<b>Signature of Physician* or Healthcare Professional</b>	<b>Date</b>	<b>Print Name and Credentials (MD, RN, etc.)</b>
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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