HEARTLAND AMBULANCE SERVICE

1-888-925-7257 **Fax: 866-222-7033**

MEDICARE

PHYSICIAN CERTIFICATION STATEMENT FOR REPETITIVE AMBULANCE TRANSPORT

General Instructions:

- **Please complete all 3 sections and have a physician or other authorized personnel sign at the bottom.**
- It is a Federal mandate that **ALL Non-Emergency** transports made by ambulance **MUST** be accompanied with a Physician Certification Statement according to 42CFR 410.40(d)(2) and (d)(3), which assists in the determination of Bed-confined status and Medical Necessity.
- Upon completion and signature you present it to the EMS personnel at the time of the transport.

Patient Demographics:

Origin:	
DOB:	**Diagnosis:**
Beginning Date of Transfer: ____ / ____ / _____	**SS #:** _____ - ____ - _____
Ending Date of Transfer: ____ / ____ / _____	**Medicare #:** _____ - ____ - _____ - ____
Destination:	

Patient Label

Section 1: Ambulance transportation is medically necessary for the following reason: (SELECT ONE)

____ A) **Bed Confined** – The patient is:

(ALL THREE MUST APPLY)

- Unable to get up from bed without assistance; **AND**
- Unable to ambulate; **AND**
- Unable to sit in a chair or wheelchair (without restraints)

____ B) The patient is:

- **ABLE** to get up from bed without assistance?

  YES or NO

- **ABLE** to ambulate?

  YES or NO

- **ABLE** to sit in chair or wheelchair (without assistance)

  YES or NO

____ C) Other means of transport are contraindicated because it would be harmful to the patient's condition. (Significant medical documentation must accompany these claims.)

Section 2: Please select ***ALL PHYSICAL CONDITIONS*** that qualify the patient for ambulance opposed to any other means:

- ☐ Decreased Level of Consciousness (specify severity / type below)
- ☐ Combativeness / Risk of self endangerment
- ☐ Contractures
- ☐ CVA w/paralysis (specify location below)
- ☐ Decubitus (specify location / stage below)
- ☐ Degenerative aging process (specify debility below)
- ☐ End stage disease (specify below)
- ☐ Fetal positioning
- ☐ Hemorrhaging (specify type below)
- ☐ Head injury (specify type below)
- ☐ Isolation patient (specify type / cause below)
- ☐ Quadriplegia
- ☐ Severe pain or distress exacerbated with exertion or movement (specify below)
- ☐ Terminal Condition (specify below)
- ☐ Total hip replacement & cannot sit safely
- ☐ Unconscious / Comatose (specify below)
- ☐ Unstable fracture / Possibility of fracture
- ☐ Vegetative state (specify cause below)

Section3: If the patient requires ambulance transportation based on the need for continual medical supervision, and any other means of transportation would be contraindicated because it may endanger or exacerbate the patient's condition, please select ***ALL*** of the following services that would apply and give any specifics on the line provided:

- ☐ Airway Management
- ☐ Body Cast
- ☐ EKG Monitoring
- ☐ Fall Precautions
- ☐ Flight Risk
- ☐ Immobilization
- ☐ Isolation Precautions
- ☐ IV Therapy / Monitoring
- ☐ Medication Monitoring / Administration
- ☐ Oxygen Therapy (pt unable to maintain)
- ☐ Restraints
- ☐ Sedation / Chemical Restraints
- ☐ Seizure Precautions
- ☐ Vent Dependant
- ☐ Wound Precautions

Notes / Specify condition:_____

I certify that the information listed above represents an accurate assessment of the patient's status and need for ambulance transportation. Repetitive Ambulance transfer PCS forms must be signed and dated by attending Physician. PCS must be dated no earlier than 60 days in advance of the transport for those patients who require repetitive ambulance services and whose transportation is scheduled in advance. PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days

Physician Signature: _____ UPIN #: _____ Date: _____ / _____ / _____

Printed Name: _____