# Physicians Certification Statement
# For Non-Emergency Ambulance Transportation

## Section 1 - Patient Information

| | | |
|---|---|---|
| Initial Transport Date | Repetitive Transport Expiration Date (Max. 60 days) | |
| Name: | D.O.B. | Patient SSN# |
| Medicare No.: | | |
| Is the patient's stay covered under Medicare Part A (PPS or DRG) Benefits for this date of service? ☐ yes ☐ no | | |
| Is this a round trip transport? ☐ yes ☐ no | | |
| Transported from: | Transported to: | |

## Section 2 - Medical Necessity Information

***Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either:***
***1) Bed confined or 2) Suffer a condition such that transport by ambulance is medically required. To be "bed confined" the patient must be unable to get up from bed without assistance; AND unable to ambulate; AND unable to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)***

1. Is the patient "bed confined" as defined above? ☐ yes ☐ no
2. What MEDICAL or PHYSICAL CONDITION does the patient present ON THE DATE OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance: _____
3. Can this patient be safely transported via wheelchair? ☐ yes ☐ no

## Section 3 - Signature

I certify that the above information is true and correct based on my evaluation of this patient, the best of my knowledge and professional training, and that this patient requires ambulance transport. I understand that this information will be used by the Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS") to support the determination of medical necessity for ambulance services.

_____ _____ _____
**Signature of Physician or Healthcare Professional** **Date Signed** **Telephone**

Print Name: _____
*If signed by a Healthcare Professional, other than the attending physician, please circle title of signer below:*

- Physician's Assistant (PA) • Clinical Nurse Specialist (CNS) • Registered Nurse (RN)
- Nurse Practitioner (NP) • Discharge Planner

*Statements for repetitive transport patients must be signed by the physician.

**Fax Completed Form to (814) 870-1950 Questions? Please Call (814) 870-1030**