GEMS AMBULANCE
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PHYSICIAN CERTIFICATION STATEMENT FOR NON-EMERGENCY AMBULANCE SERVICES

SECTION I – GENERAL INFORMATION

Patient's Name: _____ **Date of Birth:** _____ **Medicare #:** _____

Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below)

Origin: _____ **Destination:** _____

Is the patient's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Is the patient being transported to the closest appropriate facility? ☐ YES ☐ NO If no, why is transport to a more distant facility required?

_____

If hospital to hospital transfer, describe the services needed at the second facility not available at the first facility:

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

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 "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) **Describe the MEDICAL CONDITION** (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition.

2) Is the patient "bed confined" as defined as below: ☐ YES ☐ NO
To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?) ☐ YES ■ NO

4) **In addition** to completing sections 1-3 above, any of the following conditions that apply must be checked below*:
*Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

- ☐ Cardiac monitoring required enroute
- ☐ Contractures
- ☐ Danger to self/other
- ☐ DVT requires elevation of a lower extremity
- ☐ Hemodynamic monitoring required enroute
- ☐ IV medications/fluids required
- ☐ Medical attendant required
- ☐ Moderate/severe pain on movement
- ☐ Morbid obesity requires additional personnel/equipment to safely handle patient
- ☐ Need or possible need for restraints
- ☐ Non-healed fractures
- ☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
- ☐ Patient is comatose
- ☐ Patient is combative
- ☐ Patient is confused
- ☐ Requires oxygen – unable to self administer
- ☐ Special handling/isolation/infection control precautions required
- ☐ Unable to sit in a wheelchair due to decubitus ulcers or other wounds
- ☐ Unable to tolerate seated position for time needed to transport

☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

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 and that other forms of transport are contraindicated. 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.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____ _____

Signature of Physician* or Healthcare Professional **Date Signed**
(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date)

_____

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

*Form must be signed only by the patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check the appropriate box below):

☐ Registered Nurse ☐ Physician ☐ Discharge Planner ☐ Clinical Nurse Specialist ☐ Physician Assistant ☐ Nurse Practitioner

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