PHYSICIAN CERTIFICATION STATEMENT OF MEDICAL NECESSITY

Alert Ambulance Service, Inc.
Phone: (800) 950-6299 Fax: (508) 675-9920

Patient Name: _____ Date of Transport: _____
repetitive trips valid for 60 days

Physician Name: _____ Physician Fax: _____

Patient Diagnosis: _____

Transported from: _____ Transported to: _____

Why is the patient traveling from point A to point B?

*Transportation from hospital to hospital (or SNF to SNF) is **ONLY** covered is the patient is going to receive a particular type of care or procedure that is **NOT AVAILABLE** at the sending facility.*

1. If the patient is traveling between like facilities, which services or procedures will be provided at the receiving facility that are not available at the sending facility?

_____

2. If the patient is traveling to an outpatient department, which services will be provided?

A) Scheduled clinic visit _____ C) Therapy (type) _____

B) X-ray (type) _____ D) Other _____

Why is the patient traveling from point A to point B via AMBULANCE?
(What is the medical necessity for the ambulance?)

MEDICAL NEED FOR AMBULANCE CAN ONLY BE MET THROUGH ONE OF THE FOLLOWING CATEGORIES:

A. ____ Bed Confined: The patient is unable to get out of bed without assistance AND unable to ambulate AND unable to sit in a wheelchair due to: _____
Specific bed-confining condition must be listed

B. ____ Other: wheelchair or private vehicle transportation is contraindicated because it may endanger the health of the patient due to:

- ❑ Requires continuous O_2 and certified technician
- ❑ Requires airway management or suctioning
- ❑ Requires cardiac monitoring
- ❑ Requires trained IV certified technicians
- ❑ Ventilator dependent – requires management
- ❑ Requires medication administration/monitoring
- ❑ Requires immobilization/splinting
- ❑ Hemorrhage or dehydration – requires certified technician
- ❑ Requires wound precautions
- ❑ Requires isolation precautions (VRE, MRSA, etc.)
- ❑ Signs of decreased level of consciousness
- ❑ Comatose – requires certified technician
- ❑ Pain/discomfort with movement
- ❑ Psychiatric condition – requires certified technician
- ❑ Requires monitoring of vital signs and overall condition due to (state condition): _____
- ❑ Patient is able to sit, but is unable to endure sitting position during travel due to (state condition): _____

***Federal regulations [section 410.40 (d) (2-33)] require a certificate of medical need to be signed by the patient's attending physician for all non-emergent ambulance transports. Ambulance suppliers must obtain a signed certification statement from the attending physician. If the ambulance supplier is unable to obtain the signed certification statement from the attending physician, a signed physician certification statement must be obtained from either the PA, NP, CNS, RN or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished.

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that the Department of Health and Human Services, Health Care Financing Administration and/or its agents will use this information to support the determination of medical necessity for ambulance services.

Name (please print): _____ Date: _____

Signature: _____

❑ MD/DO ❑ PA ❑ CNS ❑ NP ❑ RN
❑ Discharge Planner