CRITICAL LIFE
EMERGENCY MEDICAL SERVICES

Physician Certification for Ambulance Transportation

Patient's Last Name:	First Name:
SS#	Primary MD Name (Printed)
Initial Date of Service: ____/____/____	Expiration Date (Max 60 Days): ____/____/____
Origin (Pickup) Location:	Destination (Drop Off) Location:

Section I - Qualifying Documentation – *Please check any and all boxes which* supports the presumptive reasons that non-emergency ground transport by any other means than ambulance is *contraindicated.* *Supporting documentation for any boxes checked must be maintained in the patient's medical records.*

☐ **Patient is Bed Confined * *Note: In order to qualify for bed confinement under Medicare guidelines, the patient must meet all three criteria listed below:***

1. Is unable to get up from bed without assistance; 2. Is unable to ambulate; and
3. Is unable to sit in a chair or wheelchair
   - Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate or severe muscular weakness and de-conditioning
   - Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks

☐ Third party assistance/attendant required to apply, administer or regulate or adjust ***oxygen*** enroute

☐ Medications / IV Fluids required during Transport ☐ Cardiac / Hemodynamic monitoring required during transport

☐ Special Handling Required Enroute - ☐ Isolation ☐ Other (Explain) ____________________

☐ Contractures (Describe) ____________________

☐ Non-healed fractures (Describe) ____________________

☐ Moderate to severe pain on movement (Describe) ____________________

☐ DVT requires elevation of a lower extremity ☐ Morbid Obesity requires additional personnel/equipment to handle

☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit

☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity

☐ Restraints (physical or chemical) anticipated or used during transport

☐ Danger to self or others – monitoring / seclusion / flight risk (Explain) ____________________

☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)

☐ Confused, combative, lethargic, comatose

☐ Services, Treatments or Tests not available at originating facility (Describe) ____________________

☐ Transfer required as no qualified beds were available at originating facility (Describe) ____________________

☐ Other: (Describe) ____________________

Section III - Physician's Authorization:

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service. I understand that this information will be used by the Department of Health and Human Services and Medicare to support the determination of medical necessity for ambulance services.

Signature of Attending Physician: ____________________ Date: ___/___/____
or other Authorized Representative

Physician's (or Authorized Representative) Name Printed: ____________________

Physician's Telephone Number: ____________________

This authorization must be** completed and signed by the attending physician for scheduled repetitive transports. **For unscheduled or scheduled non-repetitive transports the** authorization **may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practitioner, registered** nurse or discharge planner **(employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the** time **ambulance transport is ordered or furnished.