

Physicians Certification Statement For Ambulance Transportation

TO:	Phone:	Fax:
From: Spirit Medical Transport LLC	Phone: (937) 548-2800	Fax: (937) 459-5272 Ext.

Instructions: Medicare Part B pays for ambulance transportation only if other means of transportation would endanger the beneficiary's health (42 CFR Part 410.4(d)(1)). This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance company to determine if Medical Necessity has been met. Please complete all sections of this form and have the patient's physician sign the form prior to transport.

The completed form should be faxed to Spirit Medical Transport LLC at: (937) 459-5272 Ext.

Section 1 - Beneficiary Information

Name:			Date of Service:		Run #:
Sex:	DOB:	Age:	Patient's SSN:		
Medicare No:		Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No		Medicaid No:	
Is the patient's stay covered under Medicare Part A (PPS or DRG) benefits for this date of service? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this a round trip transport? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Section 2 - Medical Necessity Information *(to be completed by physician)*

A patient is bed confined if he/she is unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair.		<small>Ref. 42 CFR 410.40(d)(1)</small>
Based on the above definition, is the patient bed confined?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical conditions resulting in bed confinement:		
If not bed confined, reason an ambulance is needed:		
<input type="checkbox"/> Contractures	<input type="checkbox"/> Non-healed fractures	<input type="checkbox"/> Moderate/severe pain on movement
<input type="checkbox"/> Danger to self/others	<input type="checkbox"/> IV meds/fluids required	
<input type="checkbox"/> Special handling/isolation required		
<input type="checkbox"/> Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute		
<input type="checkbox"/> Restraints (physical or chemical) anticipated or used during transport		
<input type="checkbox"/> Patient is confused, combative, lethargic, or comatose		
<input type="checkbox"/> Cardiac/hemodynamic monitoring required enroute		
<input type="checkbox"/> DVT requires elevation of a lower extremity		
<input type="checkbox"/> Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport		
<input type="checkbox"/> Unable to maintain erect sitting position in a chair for time needed to transport		
<input type="checkbox"/> Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks		
<input type="checkbox"/> Morbid obesity requires additional personnel/equipment to safely handle patient		
<input type="checkbox"/> Paralysis (Hemi, Semi, Quad)		

Section 3 - Physician's Authorization

I certify that the information contained in Section 2 above represents an accurate assessment of the beneficiary's medical condition(s) and that ambulance transportation is medically necessary. I also certify that our institution has furnished care or other services to the above named patient in the past. In the event that you are unable to obtain the signature of the patient or another authorized representative, pursuant to 42 C.F.R. 424.36(b)(4), I hereby sign on the patient's behalf.	
Print the name of physician ordering ambulance transportation:	
Physician or Healthcare Professional signature:	Date: _____
Forms must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the forms may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)	
<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Clinical Nurse Specialist
<input type="checkbox"/> Discharge Planner	<input type="checkbox"/> Registered Nurse
	<input type="checkbox"/> Nurse Practitioner

If you have any questions about the form or Medical Necessity, please call Spirit Medical Transport LLC at (937) 548-2800 Ext.