SUMNER COUNTY EMS
Physician Certification Statement
(Medical Necessity Form)

Fax: 615-451-6081
Schedule Transports: 615-451-0429 x113
Communications: 615-451-6070
255 Airport Rd. - Gallatin, TN 37066

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ SSN: _____

Transport Date: _____

Transport from: _____ Destination: _____

Primary Insurance: _____ Policy Number: _____

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.

Hospital-to-Hospital Transfers: What service(s) was/were not available at the 1st facility?

_____

Describe the PHYSICAL OR MENTAL CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

☐ **Bed Confined:** All three criteria below must be me to qualify for bed confinement.

1. Unable to ambulate
2. Unable to get out of bed without assistance
3. Unable to safely sit up in a wheelchair:
   - ___ Unable to maintain an erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning
   - ___ Unable to sit in a chair or wheelchair due to Stage II or greater decubitus ulcers
     buttocks ___ coccyx ___ hip ___ other ___

Please check the appropriate condition(s) listed below, if applicable, which would necessitate transport by ambulance and make all other means of transportation contraindicated based on patient safety and health. PLEASE CHECK ALL THAT APPLY.

☐ Contractures ☐ Non-healed fractures ☐ Moderate/severe pain on movement

☐ Danger to self/others ☐ IV meds/fluids required ☐ Special handling/isolation required

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

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

☐ Patient is confused, combative, lethargic, or comatose

☐ Cardiac/hemodynamic monitoring required enroute

☐ DVT requires elevation of a lower extremity

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

☐ Unable to maintain erect sitting position in a chair for time needed to transport

☐ Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks

☐ Morbid obesity requires additional personnel/equipment to safely handle patient

Describe physical or mental condition that requires patient to be transported on a stretcher in an ambulance and why other means are contraindicated:

_____

_____

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 due to the reasons documented on this form.

PRINT NAME: _____

TITLE: ☐ Attending Physician ☐ Physician Assistant ☐ Clinical Nurse Specialist
☐ Nurse Practitioner ☐ Registered Nurse ☐ Discharge Planner

SIGNATURE: _____ Date Signed _____
Physician* or Healthcare Professional