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: ______________ Is this PCS good for 60 days from the date of transport? YES ☐ NO ☐

ORIGIN: ______________________ DESTINATION: ______________________

PRIMARY INSURANCE: ______________________ POLICY NUMBER: ______________________

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is only medically necessary 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 in order to be valid, must be answered by the healthcare professional signing this form below.

1) **Hospital-to-Hospital Transfers:** What services are needed at the receiving facility that are not available at the sending facility?

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2) **Describe the PHYSICAL OR MENTAL CONDITION of this patient**, *AT THE TIME OF AMBULANCE TRANSPORTATION,* that requires the transportation on a stretcher, in an ambulance and why being transported by other means is contraindicated by the patient's condition:

____

____

3) **Is the patient *Bed Confined* as defined below?** **YES** ☐ **NO** ☐

To be "Bed Confined" the patient must satisfy ALL THREE of the following criteria:

(1) UNABLE TO GET UP FROM BED WITHOUT ASSISTANCE
(2) UNABLE TO AMBULATE;
(3) UNABLE TO SIT IN A CHAIR OR WHEELCHAIR

4) **If the patient is on Hospice, is this transport related to their terminal illness?** **YES** ☐ **NO** ☐

5) **Is the Patient's stay covered under Medicare Part A** **YES** ☐ **NO** ☐

6) In addition to completing questions 1-5 above, please check any of the following conditions that apply and would necessitate transport by ambulance, making all other means of transportation contraindicated based on patient safety and health.
PLEASE NOTE : supporting documentation for any boxes checked below must be maintained in the patient's medical records.

☐ 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 or tolerate an 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, coccyx, or hip
☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Other (please 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 that the medical necessity provisions of 42 CFR 410.40 (e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers of Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated below.

SIGNATURE: ______________________________ DATE SIGNED: ______________
Attending Physician* or Authorized Healthcare Professional

PRINTED NAME AND CREDENTIALS: ______________________________

*This form must be signed only by the patient's attending physician for *scheduled repetitive transports.*
For *non-repetitive ambulance transports,* any of the following may sign: (please check appropriate box below)

☐ATTENDING PHYSICIAN ☐NURSE PRACTIONER ☐PHYSICIAN ASSISTANT ☐CLINICAL NURSE SPECIALIST ☐REGISTERED NURSE

☐LICENSED PRACTICAL NURSE ☐SOCIAL WORKER ☐CASE MANAGER ☐DISCHARGE PLANNER