SUMNER COUNTY EMS

Physician Certification Statement
(Medical Necessity Form)

Fax: 615-451-6081
Schedule Transports: 615-451-0429 x 113

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: _____ AUTH# _____

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?

_____

2) **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 being transported by other means is contraindicated by the patient's condition:

_____

_____

3) **Is the patient <u>bed confined</u> 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; AND
(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.

☐ Special handling/isolation/infection control precautions required	☐ Need or anticipated need for restraints	☐ Patient is confused
☐ DVT requires elevation of a lower extremity	☐ IV meds/fluids required	☐ Danger to self/other
☐ Orthopedic device (backboard, halo, pins, traction, brace,	☐ Requires oxygen – unable to self-administer	☐ Non-healed fractures
wedge etc.) requiring special handling during transport	☐ Hemodynamic monitoring required enroute	☐ Contractures
☐ Unable to tolerate seating position for time needed to transport	☐ Cardiac monitoring required enroute	☐ Patient is comatose
☐ Unable to sit in a chair/wheelchair due to decubitus ulcers/wounds	☐ Medical attendant required	☐ Patient is combative
☐ Morbid obesity requires additional personnel/equipment to safely handle patient	☐ Moderate/severe pain on movement due to: _____ _____	☐ Unable to safely maintain seated position in a wheelchair for duration of transportation
☐ Other (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 10.40(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 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 of the credentials indicated below.

SIGNATURE: _____ DATE SIGNED: _____
Attending Physician* or Authorized Healthcare Professional

PRINTED NAME & CREDENTIALS: _____

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

☐ Attending Physician ☐ Nurse Practitioner ☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Licensed Practical Nurse ☐ Social Worker ☐ Case Manager ☐ Discharge Planner