Physician Certification Statement for Non-Emergent Ambulance Transport

Please fax completed form to Tennessee Carriers Inc. (901) 339-2182

Patient Name: _____ Address: _____

Date of Birth: _____ Medicare #: _____

According to 42CRF 410.40 (d): Medical necessity requirements – (1) General rule. …Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that the other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determination. For a beneficiary to be considered bed-confined, all three of* the following criterion must be met:

1) The beneficiary is unable to get up from bed without assistance
2) The beneficiary is unable to ambulate
3) The beneficiary is unable to sit in a chair or wheelchair (*emphasis and test added)

The person indicated below hereby certifies and states as follows:

1) Is this patient "bed confined" as defined in the CFR? Yes No
2) Does the patient have contractures? Yes No
3) Describe any other/additional conditions which require this patient to be transported via stretcher by licensed ambulance and crew. Please be specific as to why transport by other means would be detrimental to or contraindicated by the patient's condition:
   _____
   _____
   _____
   _____

The following are some factors to consider, please check any of the following conditions that may apply:

☐ Non-healed fractures (if so, what location?): _____
☐ Danger to self/others (if so, why?): _____
☐ IV meds/fluids or ☐ Oxygen (cannot self-administer) required
☐ Special handling/isolation required due to: _____
☐ Restraints (physical or chemical) anticipated or used during transport due to: _____
☐ Patient is confused, combative, lethargic, or comatose
☐ Cardiac or ☐ hemodynamic monitoring required
☐ DVT requiring elevation of lowed extremity
☐ Orthopedic device requiring special handling during transport
☐ Patient unable to safely maintain sitting position in a wheelchair during transport
☐ Decubitus ulcers causing pain during transport (if so, what location?) _____
☐ Other causes of moderate to severe pain or movement due to: _____
☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Other: Please specify: _____

I am familiar with the patient identified above and certify that the above information is true and correct to the best of my knowledge. It is my medical opinion that for the reasons state above that the patient above requires transport by ambulance.

_____ _____

Signature of Physician* or Healthcare Professional Date Signed (Note: for repetitive transports, this form is good for 60 days unless otherwise indicated)

UPIN/Credentials: _____

**This form must be signed by patient's attending physician for scheduled, repetitive transports. For no repetitive, unscheduled ambulance transports, the form may be signed by any of the following who are familiar with patient if the attending physician is unavailable to sign (please check appropriate box below) (see 42CFR 410.40 (d)(2) and (d)(3))*

☐ Physician Assistant ☐ Clinical Specialist ☐ Registered Nurse

☐ Nurse Practitioner ☐ Discharge Planner