PROCARE

INTEGRATED HEALTH AND TRANSPORT

Phone 410-823-0030
Fax 410-823-7475

PHYSICIAN'S CERTIFICATION STATEMENT OF MEDICAL NECESSITY FOR AMBULANCE TRANSPORT

PATIENT'S NAME			DOB	INSURANCE POLICY #
TRANSPORT DATE	RUN#	TRANSPORTED FROM		TRANSPORTED TO

In my professional medical opinion, this patient requires an ambulance.

PLEASE CHECK ALL THAT APPLY:

☐ **This patient is currently bed-confined per Medicare/CMS regulations.**
The definition of Bed-Confined is: The inability to get up from bed without assistance, ambulate, and/or sit in a chair, including a wheelchair.
The patient is bed confined secondary to (Must Explain): ____________________

AND/OR

☐ **This patient does not meet bed-confined criteria, but the patient's medical condition is such that transportation by ambulance is medically necessary or the patient cannot be safely transported by wheelchair van.**

Patient cannot be transported safely in a wheelchair van due to:

- ❒ **Unable to hold self in w/c due to: ____________________**
- ❒ **Unable to sit duration of transport due to:____________________**
- ❒ **Overall wasting, too weak to sit up due to: ____________________**
  Paralysis:_____hemi_______semi_______quadriplegic
  Fracture of the:_____hip_neck__spine_____Knee_______leg________other ____
  Contractures of the:_____Upper R/L______Lower R/L Extremity(s)
- ❒ **Severe pain due to: ____________________**
- ❒ **Abnormally stiff and rigid due to: ____________________**
- ❒ **Decubitus ulcers of the:_____Sacrum______Buttocks______Coccyx______Hip**
- ❒ **Other (describe) ____________________**

Patient Requires Medical Monitoring:

❒ Airway/ Suctioning	❒ Danger to Self	❒ Seizure Precautions	❒ EKG
❒ Vent Dependant	❒ Combative/ Hostile	❒ Needs Restraints	❒ Cardiac Cath Transport
❒ Isolation Precautions	❒ Flight Risk	❒ IV/ Rx	❒ STEMI Transport
❒ Unable to self administer O2		❒ Altered Level of Consciousness	

❒ Other / Further description of the medical condition(s) set forth herein:
____
____

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FROM THIRD PARTY PAYERS SUCH AS THE MEDICARE PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, MAY BE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND/OR STATE LAWS. THE EXECUTION OF THIS DOCUMENT DOES NOT GUARANTEE THAT THIS TRANSPORT WILL BE COVERED BY INSURANCE.

PRINT NAME:____________________TITLE: (Circle one)MD / PA / NP / RN Disch Planner

SIGNATURE:____________________ DATE:____________________

THIS COMPLETED FORM MUST BE GIVEN TO THE CREW UPON THEIR ARRIVAL.

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