Please Fax forms to
Fax: 410-823-7475
Phone: 410-823-0030

PHYSICIAN'S CERTIFICATION STATEMENT OF MEDICAL NECESSITY FOR NON-EMERGENCY AMBULANCE

Patient Name	DOB	Medicare #

Transport Date	Run #	Origin	Destination

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. **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the Medical Condition (Physical and/or Mental) of this patient AT THE TIME OF THE AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient condition.
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2) Is this patient " Bed Confined" as defined below? ☐ Yes ☐ No
To be "Bed Confined" the patient must satisfy all three of the following conditions (1) Unable to get up from bed without assistance, AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.

3) Can this patient be safely transported by car or wheelchair van (i.e. seated during transport, without medical attendant or monitoring)?
☐ Yes ☐ No

4) **In Addition** to completing questions 1-3 above, please check any of the following conditions that apply and are supported by medical records:
☐Contractures ☐Non-healed fractures ☐Patient is Confused ☐Patient is comatose ☐Moderate/Severe Pain
☐Danger to Self/Other ☐IV Meds/Fluids required ☐Patient is combative ☐Need or possible need for restraints
☐DVT Requires elevation of a lower extremity ☐Medical attendant required ☐Requires oxygen (unable to self administer)
☐Special handling/Isolation/infection control precautions required ☐Unable to tolerate seated position for time needed

5) Under Medicare Part A Stay? ☐ Yes ☐ No Going to Closest Appropriate Facility? ☐ Yes ☐ No If not Why?
(Choose no if Hospital Discharge)
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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 and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this line is checked,** I also certify that the patient is physically or mentally incapable of signing the ambulance service's report and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, **the specific reason(s) that the patient is physically or mentally incapable of signing the report form is as follows:** ☐ Physical Disability ☐ Mental Disability

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_______________________________ _______________________________

Signature of Physician or Healthcare Professional **Date Signed**

_______________________________ (Circle One) - MD / PA / RN / Discharge Planner

Print Name

(For Scheduled Repetitive Transports, this form is not valid for transports performed more than 60 days after date signed)

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