Hart to Heart TRANSPORTATION
The vital link in community health care

Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Origin: _____ Destination: _____

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to a more distant facility required? (only legitimate reason is lack of available bed)

_____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe: _____

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 AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

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 safely be transported by car or wheelchair van? ☐ Yes ☐ No
In other words, can the patient be seated during transport without a medical attendant or monitoring?

4) ***IN ADDITION*** to completing questions 1-3 above, please check any of the following conditions that apply.
(Supporting documentation for any checked box must be maintained in the patient's medical records.)

Contractures: ☐ Right hip ☐ Left hip ☐ Right knee ☐ Left knee ☐ Unhealed fractures ☐ IV meds/fluids

☐ Medical attendant required for clinical observation - Why? _____

☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds ☐ Requires oxygen – unable to self-administer

☐ Safety – Risk of sliding out of wheelchair due to postural instability ☐ Moderate/severe pain on movement (pain level)_____

☐ Unable to tolerate seated position for time needed to transport ☐ Decubitus wound (loc./stage)_____

☐ Morbid obesity requires extra personnel/equipment to safely handle ☐ Nervous system disorder (Parkinson, Multiple Sclerosis, etc.)

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

PSYCHIATRIC TRANSPORTS: ☐ Medicated prior to transport ☐ Danger to self/others ☐ Need/possible need for restraints
☐ Attempted suicide ☐ Hallucinations ☐ Psychosis ☐ Elopement risk ☐ Other _____

CANCELED AIR AMBULANCE: ☐ Patient's medical condition meets appropriateness for air ambulance service, but the flight was aborted due to bad weather and transfer is taking place by ground transport.

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify the above information is true and correct based on my evaluation of this patient and represent that the patient requires transport by ambulance and all other forms of transport are contraindicated. I understand 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.

(NPI and PTAN below are not required for same-day requests.)

_____ _____ _____
Signature of Physician or Healthcare Professional* *NPI* *PTAN***

_____ _____
Printed Name and Credentials of Healthcare Professional (MD, DO, RN) *Date Signed*

_____
Practice Address

(NOTE: For scheduled repetitive transport, this form is only valid for transports performed within 60 days of above date.)

**** Form must be signed only by the patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, the following may sign (check appropriate box):***

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

***** While Medicare only requires the NPI number for claims submission, the PTAN number is assigned by Medicare to authenticate a provider when using the local Medicare Administrative Contractor's (MAC) self-help tools like the IVR, Internet portal, online application status, etc.***