

# Providence Transportation

## Physician Certification Statement for Ambulance Transportation

Please print clearly and sign where indicated below. Complete Sections I, II and III of this form.

### Section I—Patient Information /Reason for Transport

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date/Time of Service \_\_\_\_\_

Transport From \_\_\_\_\_ Transport To \_\_\_\_\_

Patient status at referring facility is:  Inpatient  Observation  Outpatient

#### Reason for Transfer (Check only one):

Procedure/Services are **UNAVAILABLE** at the current facility

List specific procedure/service that is needed: \_\_\_\_\_

Transfer request is for preferred physician or facility/provider (Services or procedures needed are **AVAILABLE** at current facility)

BLS discharge to \_\_\_\_\_ (SNF, Rehab, Residence, etc.)

### Section II— Qualifying Documentation for Ambulance Transportation

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. **Supporting documentation for any boxes checked below must be maintained in the patient's medical records.**

To be "**bed confined**" the patient must be: (1) unable to get up from bed without assistance; **AND** (2) Unable to ambulate; **AND** (3) unable to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify for bed confined)

Is this patient "bed confined" as defined above?  Yes  No

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

#### **Below are qualifying reasons for ambulance transportation. Please check all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> Unable to maintain or tolerate sitting position in a chair for time needed to transport    | <input type="checkbox"/> Danger to self or others during transport   |
| <input type="checkbox"/> Unable to sit in chair/wheelchair due to decubitus ulcers on buttocks (Grade II or higher) | <input type="checkbox"/> Confused, combative, lethargic, comatose  |
| <input type="checkbox"/> Requires oxygen—unable to self administer  | <input type="checkbox"/> Requires airway maintenance or suctioning (vent, BiPAP, trach)  |
| <input type="checkbox"/> I.V. medications/fluids required during transport  | <input type="checkbox"/> Orthopedic device (halo, pins, traction, brace, wedge) requiring special handling or positioning during transport |
| <input type="checkbox"/> Cardiac/Hemodynamic monitoring required during transport                                   | <input type="checkbox"/> Seizure prone and requires monitoring   |
| <input type="checkbox"/> Requires isolation precautions (VRE, MRSA, etc.)   | <input type="checkbox"/> Severe muscular weakness/de-conditioning  |
| <input type="checkbox"/> Contractures   | <input type="checkbox"/> Need or possible need for restraints (Chemical or physical)   |
| <input type="checkbox"/> Needs to remain immobile due to fracture or suspected fractures                            | <input type="checkbox"/> Weight limit exceeds wheelchair safety limitations (250 lbs.)   |
| <input type="checkbox"/> DVT requires elevation of a lower extremity  | <input type="checkbox"/> Moderate to severe pain on movement   |
|   | <input type="checkbox"/> Other (specify) _____   |

**Section III—Ordering Physician Information and Signature** I certify that the above information is true and correct based on my evaluation of this patient. 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 service.

\_\_\_\_\_  
Signature of Physician /Healthcare Professional

\_\_\_\_\_  
Date/Time Signed

\_\_\_\_\_  
Printed Name/Credentials of Physician/Healthcare Professional

This authorization must be completed and signed by the attending physician for scheduled repetitive transports. For unscheduled or scheduled non-repetitive transport the authorization may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practitioner, registered nurse or discharge planner (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.

