# PHYSICIANS CERTIFICATION STATEMENT

## SECTION I - GENERAL INFORMATION

**To:** PINELLAS COUNTY EMS D/B/A SUNSTAR **Phone:** (727) 587-2111 **Fax:** (727) 582-2540

**From:** _____ **Phone:** _____ **Fax:** _____

**Name:** _____ **DOB:** _____ **Patient's SSN:** _____

**Date of Service:** _____ **Run #:** _____ **Medical Record #:** _____

**Origin:** _____ **Destination:** _____

**Insurance #:** _____ **Medicare #:** _____ **Medicaid #:** _____

**Is the patient's stay covered under Medicare Part A (PPS or DRG)?** ☐ **Yes** ☐ **No** **Round Trip:** **Yes** ☐ **No** ☐

**Closest appropriate facility?** ☐ **Yes** ☐ **No** **If No, why is distant transfer required?** _____

## SECTION II - MEDICAL NECESSITY QUALIFYING DOCUMENTATION

**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 the 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 the patient be safely transported by car/wheelchair van (seated during transport, w/out medical attendant or monitoring)?** ☐ **Yes** ☐ **No**

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

- ☐ Airway Monitoring/Suctioning
- ☐ Cardiac Monitoring required
- ☐ DVT requires elevation of lower extremity
- ☐ Non-healed fractures
- ☐ Moderate/severe pain on movement
- ☐ Combative
- ☐ Confused
- ☐ Comatose
- ☐ Danger to self/others
- ☐ Restraints anticipated enroute
- ☐ Morbid obesity - additional personnel/equipment to handle safely
- ☐ Unable to sit due to decubitus ulcers - LOCATION(S) & STAGE:
- ☐ Other: _____
- ☐ Seizure Precautions require monitoring
- ☐ Hemodynamic monitoring required enroute
- ☐ Isolation/Infection control precautions
- ☐ IV Meds/fluids required enroute
- ☐ Oxygen
- ☐ Ventilator dependent
- ☐ Unable to tolerate seated position for time needed to transport
- ☐ Orthopedic device requries special handling (Traction, halo, pins, etc)
- ☐ Contractures - LOCATION(S): ☐ Arms ☐ Legs
- ☐ Paralysis - ☐ Hemi ☐ Semi ☐ Quad
- ☐ Amputation - LOCATION(S): _____

## 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 other forms of transport are contraindicated. I understand that this information will be used by the Centers of Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

_____ _____

**Signature of Physician/Healthcare Professional** **Date**

***LPNs, CASE MANAGERS, AND SOCIAL WORKERS ARE NOT AUTHORIZED TO SIGN THIS FORM UNLESS ACTING AS THE DISCHARGE PLANNER IN ACCORDANCE WITH 42 CFR PART 410.40(d).***

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**Print name and credentials of Physician or Healthcare Professional (MD, DO, RN, etc)**

☐ Attending Physician ☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner

## FOR REPETITIVE PATIENTS - A PHYSICIAN MUST SIGN THIS FORM

Medicare Part B pays for ambulance transportation only if other means of transportation would endanger the beneficiary's health (42 CFR Part 410.20(d)(2)). This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance company to determine if Medical Necessity has been met. Please complete all sections of this form and have the patient's physician sign the form prior to transport.

**The completed form should be faxed to PINELLAS COUNTY EMS D/B/A SUNSTAR at:**

**(727) 582-2540**

**SUNSTAR AMBULANCE DISPATCH PHONE: (727) 587-2111**