
**PHYSICIAN'S CERTIFICATION STATEMENT FOR
NON-EMERGENCY AMBULANCE SERVICE**

Patient: _____ SSN: _____ DOS: ___/___/___

Patient's Chief Complaint at Time of Transport: _____

Transport From Hospital Nursing Home Residence Other _____

Transport To Hospital Nursing Home Residence Other _____

*Patient requires ambulance transportation due to the following condition(s). Select all that apply.
At least one box must be checked. If selecting "other", a description must be given.*

- Cardiac monitoring required en route
- Advanced airway management required en route (i.e. ventilator dependant, intubation, deep suctioning)
- Chemical restraint required en route
- IV fluid management required en route
- Suctioning required en route
- Airway control/positioning required en route
- Oxygen required en route and the patient is incapable of self-administration
- Restraints required en route due to danger to self and others
- Monitoring required en route due to danger to self and others
- Attendant required en route due to flight risk
- Risk of falling off wheelchair while in motion despite restraints
- Special handling required en route due to communicable disease(s)
- Special handling required en route to reduce pain associated with an orthopedic device
- Special handling required en route due to avoid further injury (i.e. decubitus, contractures, fracture, post op)
- Other _____

Comments:

- In my professional medical opinion, this patient does not require transport by ambulance and can safely be transported by other means.

By signing below I certify that the above information is correct and true based on my evaluation of this patient's current medical condition. Transportation by other means may place this patient's general welfare in jeopardy or cause impairment of bodily function. I understand this information will be submitted to the insurance provider to support the determination of medical necessity for ambulance service. Medicare memo PM AB-99-53 states that a physician certification statement can be signed by a PA, CNS, NP, RN, or discharge planner if the physician is unable to sign.

Print Name _____ Signature, title _____ Date ___/___/___

Facility _____ Phone Number _____ - _____ - _____ Ext _____

A PHYSICIAN must sign for ALL recurring trips, i.e. dialysis patients.



**This form must be faxed prior to transport.
Fax 888.570.3888 Phone 888.242.6428**