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

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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 \_\_\_\_\_

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*Patient requires ambulance transportation due to the following condition(s). Select all that apply.*

- Cancer, site \_\_\_\_\_
  - Restraints required due to combativeness due to \_\_\_\_\_.
  - Oxygen required due to \_\_\_\_\_ and the patient is incapable of self-administration.
  - Late effects of cerebrovascular disease, cognitive deficits
  - Late effects of cerebrovascular disease, hemiplegia/hemiparesis
  - Late effects of cerebrovascular disease, monoplegia of a lower limb
  - Decubitus ulcer, **circle one**: lower back, hip, buttock
  - Contractures of joints
  - Altered Mental Status
  - Asphyxia/Hypoxemia
  - Fracture, **circle one**: cervical spine, dorsal spine, lumber spine, sacrum or coccyx, pelvis, hip, femur
  - Head injury
  - Chest wall injury
  - Trunk or torso injury
  - Dependence on respirator
  - Below knee amputee
  - Above knee amputee
  - Special handling en route to reduce pain
  - Special handling en route-positioning requires specialized handling
  - Patient Safety: Danger to self or others-seclusion (flight risk)
  - Patient Safety: Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
  - Special handling en route-isolation
  - Patient Safety: Danger to self and others-monitoring
  - Airway control/positioning required en route
  - Suctioning required en route, need for titrated O2 therapy or IV fluid management
  - Chemical restraint
  - Cardiac/hemodynamic monitoring required en route
  - Other \_\_\_\_\_
  - In my professional medical opinion, this patient does not require transport by ambulance and can safely be transported by other means.
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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 \_\_\_\_\_



*This form must be faxed prior to transport.*  
Fax 757.465.5276 Phone 800.734.4161