# Samaritan Emergency Medical Service, Inc.

15410 Highway 231
Union Grove, AL 35175
Emergency – 911 Office – 1-877-919-2911 or 256-260-3469 Fax 256-498-0924

## Physicians Certification Statement for Ambulance Transport

Patient Name____________________________ Sex: M F Birthday:_____________

Incident Location:__________________________________

Destination:_______________________________________

**The Medicare definition of bed confined is:**

The inability to get up from bed without assistance and the inability to ambulate and the inability to sit in a chair, including a wheelchair.

Does the patient's condition meet Medicare's definition of bed confined? Yes No

Bed confinement as above is not the sole determination of necessity for ambulance transport. If the patient does not meet the criteria above, please describe the patient's physical condition(s) and/ medical interventions that make transportation by ambulance medically necessary:

_____ Requires continuous oxygen
_____ Requires airway monitoring or suction
_____ Ventilator dependant
_____ Continuous running IV lines
_____ Needs to be restrained (due to psychiatric illness)
_____ Requires cardiac EKG monitoring
_____ Requires isolation precautions
_____ Is on hip precautions
_____ Exhibits signs of decreased LOC
_____ Requires wound precautions
_____ Risk of falling
_____ Old CVA with paralysis or weakness
_____ Taking narcotic medicine
_____ Quadriplegic or paralysis of lower extremities
_____ Recent Surgery
_____ Requires procedure not offer at this facility: Procedure:______________________________

_____ Other (explain): ________________________________________________________

________________________________________________________________

Physician Name (Print):_________________________________________

Physician or Authorized Signature:___________________________________ Date:__________

I certify, the above information represents an accurate assessment of the patient's medical condition(s) and in my professional medical opinion, this patient requires transport by an ambulance.

Medicare requires via 42 CFR Part 410.40(d) that ambulance providers obtain a **Physician Certification Statement** signed by the patient's physician for the provision of non-emergency ambulance transportation. This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance provider to determine of Medical Necessity has been met. Please complete all sections of this form and have the patient's physician sign the form. In the absence of the physician, a PA, NP, CNS, RN, or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, with the knowledge of the beneficiary's condition at the time of transport, may sign the form.