Physician Certification Statement for Ambulance Transportation

All fields are REQUIRED.

Physician/Authorizing Individual

Name _____

Title _____

Place of Employment _____

Ambulance Provider Number (PTAN), if applicable _____

Prior Authorization: _____

By: _____

Patient and Claim Information

Name _____

Health Insurance Claim (HIC) Number _____

Claim date(s) or span of dates being authorized

for transportation _____ to _____

Patient transported from _____

Patient transported to _____

Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. Supporting documentation for any boxes checked must be maintained in the patient's medical records.

Check all that apply:

____ Bed confined (all three must be met to qualify for bed confinement):
1. Unable to ambulate
2. Unable to get out of bed without assistance
3. Unable to safely sit up in a wheelchair

____ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning

____ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks

____ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route

____ IV medication/fluids required during transport

____ Cardiac/hemodynamic monitoring required during transport

____ Special handling en route-isolation

____ Contractures

____ Non-healed fractures

____ Moderate to severe pain on movement

____ DVT requires elevation of lower extremity

____ Morbid obesity requires additional personnel/equipment to handle

____ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transport

____ Severe muscular weakness and de-conditioned state precludes any significant physical activity

____ Restraints (physical or chemical) anticipated or used during transport

____ Danger to self or others - monitoring

____ Risk of failing off wheelchair or stretcher while in motion (not related to obesity)

____ Danger to self or others - seclusion (flight risk)

____ Confused, combative, lethargic, comatose

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date(s) of service.

Signature: _____

Date: _____

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, nurse practitioner, clinical nurse specialist, 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.

This form should be maintained on file with the medical record and submitted upon request to CGS. If requested by CGS, please fax or mail this form and any supporting documentation to the address or fax number specified in the documentation request letter from CGS.

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