Heart to Heart Medical Transport

Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name: ______________________________ Date of Birth: _____________ Medicare #: ______________________ Social Security #:_________________

Initial Transport Date: ______________ Repetitive Transport Expiration Date (Max 60 Days From Date Signed): ____

Origin: ____

Destination: ____

Is the Patient's stay covered under Medicare Part A (PPS/DRG)? ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why? ____

If hospital to hospital transfer, describe services needed at Second facility not available at first facility: ____

If hospice Pt, is this transport related to Pt's terminal illness? ☐ YES ☐ NO Describe: ____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other methods of transport are contraindicated; **OR** if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. (Bed confinement is not the sole criterion.)

The following questions must be answered by the medical professional signing below for this form to be valid:

1. Is this patient "bed confined" as defined above? ☐ Yes ☐ No
   Note: *To be "bed confined" as patient must satisfy all three of the following criteria: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.*
2. Describe the Medical CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

3. Can this patient safety be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?)
   ☐ Yes ☐ No
4. ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
   **Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Moderate/severe pain on movement
☐ Danger to self/others ☐ IV meds/fluids required ☐ Special handing/isolation required
☐ Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute
☐ Restraints (physical or chemical) anticipated or used during transport
☐ Patient is confused, combative, lethargic, or comatose
☐ Cardiac/hemodynamic monitoring required enroute
☐ DVT requires elevation of a lower extremit ☐ Medical attendant required
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport
☐ Unable to maintain erect sitting position in a chair for time needed to transport
☐ Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
☐ Morbid obesity requires additional personnel/equipment to safely handle patient

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 due to the reasons documented on this from. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

☐ If this box is checked, I also certify that the patient is physically or mentally incapable to signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.37, ***the reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:***

____

______________________________________ ____________ ____

Signature of Physician* or Healthcare Professional **Date Signed** **Print Name & Credentials**

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)*

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

Fax: 4049055137.
Email: Contact@heart2heartMedicalTransport.com
Website: heart2heartmedicaltransport.com
Phone: 6786961583