Physician Certification for Ambulance Transportation
Section I - Patient Information

Name: _____ Medicare: _____ Date of Birth: _____

Initial Transport Date: _____ Repetitive Transport Expiration Date (max 60 days from initial): _____

Destination: _____ Origin: _____

Section II - Qualifying documentation supporting 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 patients medical records.

Check all that apply:

☐ Bed Confined. All three below must be met to qualify for bed confinement.

Unable to ambulate
Unable to get out of bed without assistance
Unable to safely sit up in 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 ulcer on buttocks

☐ Third party assistance/attendant required to apply, administer, regulate or adjust oxygen enroute.

☐ IV medications/fluids required during transport.

☐ Cardiac/Hemodynamic monitoring required during transport.

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

☐ Restraints (physical or chemical) anticipated or used during transport.

☐ Morbid Obesity requires additional personnel and/or equipment to handle.

☐ Danger to self and others - medical supervision required.

☐ Danger to self and others - seclusion (flight risk).

☐ Extreme risk for falls due to weakness or other medical condition.

☐ Confused, combative, lethargic, comatose, behavioral disturbance, or altered mental status.

☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity).

☐ Special handling/positioning due to: (check all that apply).

☐ Moderate to sever pain ☐ Isolation

☐ Non-healing fractures ☐ Contractures

☐ Poor skin integrity ☐ Orthopedic Devices

☐ Extreme edema, or possible DVT requires elevation of a lower extremity

☐ Decubitus Stage _____ Location _____

Interfacility Transports

☐ No beds available at referring facility. Type of bed needed? _____

☐ Receiving facility provides specialized care, treatment and diagnostics not available at referring facility.

Define Care required and facilities needed: _____

Section III - Physician/Qualified Personnel Authorization

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

Signature of Physician or Qualified Pesonnel* Date Printed Name and Title

This authorization form must be completed and signed by the attending physician for scheduled repetitive transport.
For unscheduled or scheduled non-repetitive transports, this authorization my be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practicioner, 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 was ordered or furnished.

For questions, please contact **Logan Emergency Ambulance Service Authority** Billing Office at (304) 752-0917