



Non-Physician Certification Statement

Please complete the following information
and fax to 317-857-1481

Patients Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ (PCS is valid for round trips on this date)

Closest appropriate facility? Yes NO If no why? _____

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid:**

1. Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance.

2. Bed Confined? Yes NO *To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without Assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair.*

3. In addition to completing questions 1 and 2 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.

- | | |
|--|--|
| <input type="checkbox"/> Contractures | <input type="checkbox"/> Non-healed fractures |
| <input type="checkbox"/> Patient is Comatose | <input type="checkbox"/> Danger to self or others/combative |
| <input type="checkbox"/> Moderate/severe pain on movement | <input type="checkbox"/> IV meds/fluids required |
| <input type="checkbox"/> Need or possible need for restraints | <input type="checkbox"/> Medical attendant required |
| <input type="checkbox"/> DVT requires elevation of lower extremity | <input type="checkbox"/> Requires oxygen and unable to self-administer |
| <input type="checkbox"/> Isolation precautions required | <input type="checkbox"/> Hemodynamic monitoring required enroute |
| <input type="checkbox"/> Unable to tolerate seated position for transport | <input type="checkbox"/> Decubitus ulcers or other wounds |
| <input type="checkbox"/> Cardiac monitoring required enroute | |
| <input type="checkbox"/> Morbid obesity - requires additional equipment/personnel to safely handle patient | |
| <input type="checkbox"/> Orthopedic device (backboard, halo, pins traction, brace, wedge etc.) requiring special handling during transport | |
| <input type="checkbox"/> Other (specify) _____ | |

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 and that other forms of transport are contraindicated. 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 I represent 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 of 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 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:

(Signature) (Date) (NPI Number if applicable)

(Printed Name) MD DO PA NP RN CNS LPN Discharge Planner Social Worker Case Mgr.