

Twin City Ambulance

555 Commerce Dr, Amherst, NY 14228

Phone: 692-2100 FAX: 692-3297

Physician Certification Statement Certificate of Medical Necessity

Patient Name _____
DOB _____ SSN _____
MRN or Facility ID: _____

Please place patient registration label here, or complete by hand.

Transport Information – ALL Fields Required

(Hospital EMTALA or TRANSFER Forms are NOT a substitute for PCS/CMN – may only be used as secondary documentation)

Date(s) of Service: _____

Pick up: _____

Is this a SAME DAY Round Trip transport? Yes No

For IFT, is closest / appropriate facility? Yes No

Destination: _____

Transport is for: Diagnostic Test Procedure / Treatment Specialty Care Surgery / Consult Observation / Admit
 Services not available Palliative Care / EOL Discharge (check): Home () or SNF / Rehab Svcs ()

Specialty Category: Trauma Cardiac Neuro Ortho Psych/Behav OB Pediatrics Cancer Dialysis

Supporting Medical Necessity Documentation for AMBULANCE Transport

SPECIFY MEDICAL CONDITION (physical and/or mental) **AT THE TIME OF TRANSPORT** requiring EMS personnel to medically monitor, treat, observe, and/or handle patient in an ambulance. All other means of transport being unsafe or contraindicated:

Is bed confined by all three CMS criteria? 1) unable to get up from bed without assistance; **AND** 2) unable to sit up in a chair or wheelchair; **AND** 3) unable to ambulate. Yes No Physician Ordered

Physician ordered supine, semi-fowlers, immobile, or non-weight bearing due to: _____

Mental Status: Normal (GCS 15) Dementia Confusion Comatose Impaired by Drugs/Alcohol Psychological Crisis
If GCS not 15, GCS = _____; due to Chronic Baseline Decreasing Chronic Baseline Emergent / Acute Change(s) Sedated

Additional medical care, or monitoring services to be provided: Not Applicable

- | | | |
|-----------------------------------------------------------------|-----------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Cardiac Monitoring | <input type="checkbox"/> Airway Management | <input type="checkbox"/> Oxygen required (unable to self-admin or control) |
| <input type="checkbox"/> IV or IV with Fluids | <input type="checkbox"/> Med Admin or Pump Infusion | <input type="checkbox"/> BiPAP () or CPAP () |
| <input type="checkbox"/> Suctioning | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Transport Vent (check): Pt's Own () or EMS Provided () |
| <input type="checkbox"/> Post Cardiac Arrest care | <input type="checkbox"/> Physical / Chemical restraint(s) | <input type="checkbox"/> Abnormal Vital Signs monitoring |
| <input type="checkbox"/> Specific Devices or Medications: _____ | | |

Other specific handling procedures or concerns that require medical attention during or EMS awareness for transport:

- | | | | |
|---------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> fall or flight risk | <input type="checkbox"/> combative | <input type="checkbox"/> lacks trunk control | <input type="checkbox"/> lower extremities amputee |
| <input type="checkbox"/> non-weight bearing | <input type="checkbox"/> Danger to self / others | <input type="checkbox"/> Fragile / weak | <input type="checkbox"/> moderate to severe pain on movement |
| <input type="checkbox"/> contracture(s) | <input type="checkbox"/> decubitus ulcers | <input type="checkbox"/> fractures / dislocations | <input type="checkbox"/> infection(s) or isolation control |
| <input type="checkbox"/> Limb(s) elevation | <input type="checkbox"/> Morbid obesity (weight: _____) | <input type="checkbox"/> mechanical lift (i.e. hoist) or 2+ person lift | |
| <input type="checkbox"/> Other, not listed: _____ | | | |

I certify that the above is accurate based on my evaluation of this patient, and personal knowledge of the patient's condition at time of transport, which meets the medical necessity provisions of 42 CFR 410.40(e)(1), requiring transportation by ambulance. I understand this information will be used by the Centers for Medicare & Medicaid Services (CMS) and/or other insurances to support or prove medical necessity. I meet all applicable Medicare and State licensing requirements for the credential indicated below.

Signature of Physician or Healthcare Professional (NO STAMP)

Printed Name

Physician PA NP RN CNS LPN

Discharge Planner Case Manager Social Worker

Date Signed