



Physician's Medical Necessity Certification

Complete for non-emergency ambulance transportation – scheduled or unscheduled

PHONE: (361) 857-2059 / FAX: (361) 857-0439

In order for ambulance services to be covered, they must be medically necessary and reasonable. This form provides the information needed to make medical necessity determinations for non-emergency ambulance transportation.

Beneficiary's Name: _____

Date of Birth: _____ Date of Trip: _____

PLEASE CHECK ALL THAT APPLY:

- Bed Confined** - The patient is: (all three conditions must apply), unable to get up from bed without assistance; *and*, unable to ambulate; *and*, unable to sit in a chair or wheelchair.
- Stretcher Only** - Other means of transportation are contraindicated because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. Significant medical documentation must accompany these claims.
- Psychiatric assistance** and/or restraints due to patient and/or others safety: Alzheimer's, Disoriented, psychosis, schizophrenia, dementia, or psychiatric behavior.

List condition(s) which necessitates the transport

PLEASE CHECK ALL THAT APPLY:

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Altered Mental Status <input type="checkbox"/> Hemiplegic/Paralysis/Quadriplegic <input type="checkbox"/> Contractures to LE / UE , Bent or 90 Degrees, Fetal <input type="checkbox"/> Terminal and/or Debilitated Cancer <input type="checkbox"/> Recent Fracture (Hip/Back/Femur) <input type="checkbox"/> AKA / BKA (Right / Left / Bilateral) <input type="checkbox"/> Unsteady Gait and/or Nonweight Bearing / Recent LE Fx's) | <ul style="list-style-type: none"> <input type="checkbox"/> Debilitated Physical Condition <input type="checkbox"/> Recent CVA or late effects of CVA <input type="checkbox"/> Requires Life Sustaining Device (Oxygen) <input type="checkbox"/> Recent Head Injury <input type="checkbox"/> DECUBITUS (Stage III or Higher / Nonweight Bearing) <input type="checkbox"/> Morbid Obesity _____ LBS <input type="checkbox"/> Recent _____ Surgery |
|--|---|

OTHER _____

Any medical staff that falsely attests a prescribed ambulance transport, and knowingly or willfully makes or causes to be made false any statement or representation of material fact in any application for benefits or payments under the Medicare law shall be guilty of a misdemeanor. Conviction thereof may result in a fine, imprisonment, or both. A false attestation can result in civil monetary penalties and a fine of as much as \$10,000.00 per item. For non-emergency ambulance transports, Medicare requires, in accordance with CFR 410.40, a Physician Certification Statement (PCS) from the patient's attending physician certifying that medical necessity requirements for ambulance transportation are met. If unable to obtain the PCS from attending physician, a PCS may be obtained from a RN, PA, NP, CNS, or Discharge Planner knowledgeable of the patient's condition(s). **THIS CERTIFICATE IS GOOD FOR 60 DAYS.**

<p>AUTHORIZED SIGNATURE OF ATTESTATION:</p> <p>Print Name: _____</p> <p>Signature: _____ DATE: _____</p> <p>I hereby certify that the stretcher was medically necessary.</p>	<p style="text-align: center;">SIGNER OF THIS DOCUMENT IS:</p> <table border="0" style="width: 100%;"> <tr> <td>Attending Physician _____</td> <td>Primary Physician _____</td> </tr> <tr> <td>Registered Nurse (RN) _____</td> <td>Discharge Planner _____</td> </tr> <tr> <td>Nurse Practitioner (NP) _____</td> <td>Clinical Nurse _____</td> </tr> <tr> <td>Physician Assistance _____</td> <td>Other: _____</td> </tr> </table>	Attending Physician _____	Primary Physician _____	Registered Nurse (RN) _____	Discharge Planner _____	Nurse Practitioner (NP) _____	Clinical Nurse _____	Physician Assistance _____	Other: _____
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