PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Physician Certification Statement for Ambulance Transportation

***ALL** fields are **REQUIRED**.*

Physician / Authorizing Individual

Name:

Title:

Place of Employment:

Ambulance Provider Number (PTAN) if applicable:

Patient and Claim Information

Patient Name:

Medicare Beneficiary Identifier (MBI/HIC):

Claim Date(s) or span of dates being authorized for transportation

From: ___ / ___ / ___ To: ___ / ___ / ___

Patient transported from:

Patient transported to:

Qualifying documentation supporting presumptive 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 patient's medical records.**

Check all that apply:

- ☐ Bed Confined *

* All three must be met to qualify for bed confinement: 1) Unable to ambulate; (2) Unable to get out of bed without assistance; (3) Unable to safely sit up in a 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 ulcers on buttocks.
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medication/fluids required during transport
- ☐ Cardiac/hemodynamic monitoring required during transport
- ☐ Special handling en route-Isolation
- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Moderate to severe pain on movement
- ☐ DVT requires elevation of lower extremity
- ☐ Morbid obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transport
- ☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others - monitoring
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity
- ☐ Danger to self or others - seclusion (flight risk)
- ☐ Confused, combative, lethargic, comatose

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

Signature: _____ Date: _____

This authorization must be completed and signed by the authorizing individual for scheduled repetitive transports. Some scheduled repetitive transportation must be reauthorized every sixty (60) days. For unscheduled or scheduled non-repetitive transport the authorization may be signed by the attending physician, physician assistant, clinical nurse special, nurse practitioner, 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 is ordered or furnished.

This form should be maintained on file with the medical record and submitted upon request to Palmetto GBA. if requested by Palmetto GBA please fax or mail this form and any supporting documentation to the address or fax number specified in the documentation request letter from Palmetto GBA