Physician's Certification Statement For
Non-Emergency Ambulance Service

Patient: ________________________ **SSN:** _____________ **Date:** _____________
Chief Complaint: ____
Transport From: □ Hospital □ SNF □ Residence □ Other: _______________
Transport To: □ Hospital □ SNF □ Residence □ Other: _______________

Patient requires ambulance transportation due to the following condition:

- □ **Airway control or positioning required en route**
- □ **Altered Mental Status, Etiology:** _______________________________________
- □ **Amputation of lower extremity, Site:** __________________ **BKA / AKA / Other**
- □ **Asphyxia or Hypoxemia, Etiology:** ____________________________________
- □ **Cancer, Site:** ____
- □ **Cardiac or Hemodynamic Monitoring required en route**
- □ **Cerebrovascular disease, WITH: Cognitive Defects**
- □ **Cerebrovascular disease, WITH: Hemiparesis / Hemiplegia**
- □ **Cerebrovascular disease, WITH: Monoplegia of a lower limb**
- □ **Chest wall injury**
- □ **Contractures of extremities, Site:** ______________________________________
- □ **Decubitus ulcer, Site:** ____
- □ **Fracture, Site:** ____
- □ **Head Injury**
- □ **IV Fluid Management, Medications being administered:** __________________
- □ **Oxygen required, patient cannot self-administer, Reason:** _________________
- □ **Oxygen requiring titrated therapy en route**
- □ **Patient Safety: Danger to self or others – flight risk / monitoring**
- □ **Patient Safety: Risk of falling off wheelchair or stretcher while in motion**
- □ **Restraints required: Verbal / Physical / Chemical**
- □ **Special handling en route to reduce pain**
- □ **Special handling en route for patient positioning**
- □ **Special handling en route for Isolation, Type:** _______ **Diagnosis:** _________
- □ **Suctioning required en route**
- □ **Torso or Trunk injury**
- □ **Ventilator Dependent**
- □ **Other:** ____

By signing below I certify that the above information is correct and true based on my evaluation of this patients current medical condition. Transportation by other means may place the patient's welfare in jeopardy or cause impairment of bodily function. I understand this information will be submitted to the insurance provider to support the determination of medical necessity for ambulance transportation. Medicare memo PM AB-99-53 states that a physician's certification statement can be signed PA, CNS, NP, RN, or Discharge Planner if the physician is unable to sign.

Print Name: ______________________ Signature:____________________ Title: _________
Facility: _________________________ Phone Number: ___-____-_____ Date: _________

Please call to arrange transportation: 757-347-1226
Http://www.FastTrackEMS.com