PHYSICIANS CERTIFICATION STATEMENT

SECTION I - GENERAL INFORMATION

To: PINELLAS COUNTY EMS D/B/A SUNSTAR **Phone:** (727) 587-2111 **Fax:** (727) 582-2540

Physician: _____ **Phone:** _____ **Fax:** _____

Name: _____ **DOB:** _____ **Patient's SSN:** _____

Date of Service: _____ **Run #:** _____ **Prior Auth #:** _____ **Medical Record #:** _____

Pick-Up: _____ **Drop-Off:** _____

Insurance #: _____ **Medicare #:** _____ **Medicaid #:** _____

Is the patient's stay covered under Medicare Part A (PPS or DRG)? ☐ **YES** ☐ **NO** **ROUND TRIP:** ☐ **YES** ☐ **NO**

Closest appropriate facility? ☐ **YES** ☐ **NO** **If No, why is distant transfer required?** _____

SECTION II - MEDICAL NECESSITY QUALIFYING DOCUMENTATION

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, and why transport by other means is contraindicated by the patient's condition:**
_____

2) **Is the patient "Bed Confined? as defined below?** ☐ **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) **Can the patient be safely transported by car/wheelchair van (seated during transport, w/out medical attendant or monitoring)?** ☐ **YES** ☐ **NO**

4) ***IN ADDITION* to completing questions 1-3 above, please check any of the following conditions that apply:**

**Supporting documentation for any boxes checked must be maintained in the patient's medical records.*

- ☐ Airway Monitoring/**SUCTIONING**
- ☐ **CARDIAC** Monitoring required
- ☐ **DVT** requires elevation of lower extremity
- ☐ Non-healed **FRACTURES**
- ☐ Moderate/severe **PAIN ON MOVEMENT**
- ☐ **COMBATIVE**
- ☐ **CONFUSED**
- ☐ Comatose
- ☐ Danger to self/others
- ☐ Restraints anticipated enroute
- ☐ **MORBID OBESITY** - additional personnel/equipment to handle safely
- ☐ Unable to sit due to **DECUBITUS ULCERS** - LOCATION(S) & STAGE:
- ☐ Other: _____
- ☐ **SEIZURE PRECAUTIONS** require monitoring
- ☐ **HEMODYNAMIC** monitoring required enroute
- ☐ **ISOLATION**/Infection control precautions
- ☐ **IV MEDS**/fluids required enroute
- ☐ **OXYGEN**
- ☐ V**ENTILATOR** dependent
- ☐ Unable to **TOLERATE SEATED POSITION** for time needed to transport
- ☐ Orthopedic device requries special handling **(TRACTION, HALO, PINS**, etc)
- ☐ **CONTRACTURES** - LOCATION(☐ Arms ☐ Legs
- ☐ **PARALYSIS** - ☐ Hemi ☐ Semi ☐ Quad
- ☐ **AMPUTATION** - LOCATION(S): _____

SECTION III - SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

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 other forms of transport are contraindicated. I understand that this information will be used by the Centers of Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

_____ _____
Signature of Physician/Healthcare Professional **Date**

_____
Print name and credentials of Physician or Healthcare Professional (MD, DO, RN, etc)

AUTHORIZED INDIVIDUALS IN ACCORDANCE WITH 42 CFR 410.40(a)(i) through (iii), ARE CERTIFYING THAT MEDICAL NECESSITY IS MET IN ACCORDANCE TO 42 CFR PART 410.40(e)(1).
And are authorized by the facility to do so.

☐ **Attending Physician** ☐ **Social Worker** ☐ **LPN**
☐ **Case Manager** ☐ **Physician Assistant** ☐ **Clinical Nurse Specialist** ☐ **Registered Nurse** ☐ **Nurse Practitioner** ☐ **Discharge Planner**

FOR REPETITIVE PATIENTS - A PHYSICIAN MUST SIGN THIS FORM

Medicare Part B pays for ambulance transportation only if other means of transportation would endanger the beneficiary's health (42 CFR Part 410.20(d)(2)). This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance company to determine if Medical Necessity has been met. Please complete all sections of this form and have the patient's physician sign the form prior to transport.

The completed form should be faxed to PINELLAS COUNTY EMS D/B/A SUNSTAR at:

(727) 582-2540

SUNSTAR AMBULANCE DISPATCH PHONE: (727) 587-2111