LifeMed Alaska Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

May be completed by LifeMed Alaska crew member.

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in a 60-day range as noted below)

Origin: _____ Destination: _____

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

If interfacility transfer, describe services needed at receiving facility not available at referring facility: _____

If hospice patient, is this transport related to patients's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Cannot be completed by LifeMed Alaska crew member. Must be completed by medical professional signing Section III.

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) 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.
   Is this patient "bed confined"? ☐ Yes ☐ No

3) Can this patient safely be transported by car or wheelchair van, or commercial airline flight (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) Check any of the following conditions that apply (patient's medical records must support any boxes checked):

Acuity:
☐ Medical attendant required ☐ Requires oxygen – unable to self-administer
☐ Cardiac monitoring required en route ☐ Hemodynamic monitoring required en route
☐ IV meds/fluids required ☐ Patient is comatose

Special positioning or handling:
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Non-healed fractures ☐ Contractures ☐ DVT requires elevation of a lower extremity
☐ Moderate/severe pain on movement ☐ Unable to tolerate seated position for time needed to transport
☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

Safety:
☐ Patient is confused ☐ Special handling/isolation/infection control precautions required
☐ Patient is combative ☐ Danger to self/others ☐ Need or possible need for restraints
☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ **Other** (specify) _____

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 that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

If an attending physician is unavailable, any of the following may sign (check appropriate box):

☐ Physician Assistant ☐ Registered Nurse ☐ Clinical Nurse Specialist ☐ Social Worker
☐ Nurse Practitioner ☐ Licensed Practical Nurse ☐ Discharge Planner ☐ Case Manager
☐ This transport originated at a facility or scene where no person with any of the above credentials was available. No Signature is Required.

_____ _____
Printed Name of Physician or Healthcare Professional *Credentials (MD, DO, RN, etc.)*

_____ _____
Signature of Physician or Healthcare Professional Date Signed

☐ **If this box is checked,** I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____