NORTH MEMORIAL HEALTH

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FOR AIRCARE CALL
1-800-247-0229

"PHYSICIAN CERTIFICATION STATEMENT"

FOR AMBULANCE TRANSPORTATION

Section 1 – Beneficiary Information

Patient Name:_____ **Diagnosis:**_____

Date of transport:_____ Medicare/Medicaid #:_____

Pickup:_____ Destination:_____

Section 2 – Medical Necessity Information – (NON-EMERGENCY TRANSPORT)

☐ Yes ☐ No **1**. Can the patient be safely transported by car, taxi, bus or a wheelchair van, seated for the duration of the transport **and without** a medical attendant?

If **YES** STOP **DO NOT** order ambulance transportation as it does not meet medical necessity requirements.

2. If NO, describe <u>in detail</u> the <u>medical reason</u>(s) why the patient requires monitoring, an attendant and/or transport by ambulance. _____

_____

Section 3 – HOSPITAL TO HOSPITAL TRANSFERS ONLY

☐ Yes ☐ No **1.** Is the patient being transferred to a higher level of care?

2. Describe in detail Medical Facilities or Procedure(s) required/available at destination facility not available at originating Facility:_____

_____

☐ Yes ☐ No **3.** The patient was discharged from the originating facility.

☐ Yes ☐ No **4.** The patient is being transported to the closest appropriate facility.
If NO describe why the patient must be transported to the further facility:

_____

If NO, the patient/family has been notified they will be responsible for the additional mileage charges beyond the closest appropriate facility. ☐ Yes ☐ No

☐ Yes ☐ No **5.** The patient is critically ill or injured, unstable, or in need of immediate intervention.

AIRCARE ONLY

☐ **Yes** ☐ **No** **Due to the medical condition of the patient and/or the need for rapid transport, the patient requires transport by AIR AMBULANCE.**

Section 4 - SIGNATURE

LEGIBILY PRINT the FULL name of the Physician or Health Professional ordering transport that **signed** this **PCS:**

_____ Physician NPI:_____(if known)

SIGNATURE of Physician* or Healthcare Professional ordering transportation:

_____ Date: _____

Check appropriate box for the professional that signed this form:

☐ Physician ☐ RN ☐ Discharge Planner ☐ Nurse Practitioner ☐ PA ☐ Clinical Nurse Specialist

***Physician must sign for scheduled or repetitive transports**. For unscheduled ambulance transports, the form may be signed by any of the above if the attending physician is unavailable to sign.

I certify that the above information represents an accurate assessment of the patient's medical condition(s)and that in my professional medical opinion, this patient requires transport by an ambulance and should not be transported by any other means. I understand that this information will be used by CMS to support the determination of medical necessity.

☐ If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance services claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature above 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 incapable of signing the claim form is: _____