Rescue Nine Physician Certification Statement for Non-Emergency Ambulance Transport

Complete for ALL ambulance transports – scheduled or unscheduled, this form is required to be completed prior to transport for scheduled repetitive transports, and should be completed PRIOR to transport for a single scheduled, or unscheduled transports. This certification is effective for 60 days for repetitive transports or for a single prescheduled or unscheduled transport only.

SECTION 1-General Information

Patient Name _____ Date of Birth _____ Initial Transport Date: _____
Medicare # _____ Part B ☐Yes ☐No Medicaid # _____ Other _____
Origin_____ Destination _____
In order for Non-Emergency services to be covered, they must be medically necessary and reasonable. Medical Necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. This form provides the information needed to make the medical necessity determination for the Non-Emergency Transportation

SECTION 2-Medical Necessity Questionnaire

To be "bed confined" the patient must be : (1) unable to get up from bed without assistance; And (2) unable to ambulate; And (3) unable to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered by the medical professional below for this form to be valid:
1) Is this patient " bed confined" as defined above ? ☐ Yes ☐ No
2) Describe the medical condition of this patient at the time of ambulance transportation that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition: _____
_____
3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?) ☐ Yes ☐ No
4) **In addition** to completing questions 1-3 above, please check any of the following conditions that apply:

- ☐ Contractures
- ☐ Danger to self or others
- ☐ Recent CVA or late effects of CVA
- ☐ DTV requires elevation of lower extremity
- ☐ Cardiac/ hemodynamic monitoring required enroute
- ☐ Patient is confused, combative, lethargic, or comatose
- ☐ Restrains (physical or chemical) anticipated or used during transport
- ☐ Morbid obesity requires additional personal/ equipment to safely handle patient
- ☐ Unable to sit in the a chair or wheelchair due to Grade 2 or greater decubitus ulcers on buttocks
- ☐ Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport
- ☐ Recent _____ surgery
- ☐ Other _____
- ☐ Non-healed fractures
- ☐ IV meds/fluids required
- ☐ Hemiplegic/ Paralysis/ Quadriplegic
- ☐ Moderate/severe pain on movement
- ☐ Special handling/ isolation required
- ☐ Debilitated physical condition
- ☐ Generalized weakness

SECTION 3 – SIGNATURE OF PHISICIAN 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 due tot the reasons documented on this form. 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 that I have personal knowledge of the patient's condition at the time of transport.

☐ **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:***_____

_____ _____
Signature of Physician* or Healthcare Professional **NPI** **Date signed**

_____ _____
Print Name of Physician* or Healthcare Professional & Credentials **Address**

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, this form may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)*

- ☐ Attending Physician
- ☐ Nurse Practitioner
- ☐ Clinical Nurse Specialist
- ☐ Discharge Planner
- ☐ Registered Nurse
- ☐ Physician Assistant