

PHYSICIAN'S CERTIFICATION STATEMENT – AMBULANCE NECESSITY

Southern Berkshire Volunteer Ambulance Squad, Inc.

Patient name: _____ Medicare #: _____

Transported from: _____ Transported to: _____

In my professional opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required.

The CMS definition of bed confined is:

The inability to get up from bed without assistance; ambulate and sit in a chair, including a wheelchair.

* Is the patient bed confined as defined by Medicare (CMS) regulation? Yes No

* If the patient does not meet the bed confined criteria, can this patient be transported safely in a wheelchair van? Yes No

If no, check reasons below why:

- Requires continuous oxygen & monitoring by trained staff
 - Requires Airway monitoring or suction
 - Is comatose and requires trained monitoring
 - Is seizure prone & requires trained monitoring
 - Requires isolation precautions (VRE, MRSA, etc.)
 - Is not wheelchair able (should not stand, pivot, or is unable to safely assist with moving self)
 - Has signs of altered level of consciousness
 - Other _____
- Requires restraints
 - Requires IV monitoring
 - Is ventilator dependent
 - Has decubitus ulcers with wound precautions

Patient condition & relevant history supporting ambulance transport necessity:

I certify that the above information is true and correct based on my evaluation of the patient, to the best of my knowledge and professional training. I understand this information may be used as support documentation in the determination of medical necessity for ambulance services.

Signature of Physician, Physician Assistant, Licensed Nurse Practitioner

Date signed

Printed Name

***** **OR** *****

I certify that I am the RN or Discharge Planner assigned to this case and have verbally received permission from the physician to sign in lieu of them. I certify the above statements are true to the best of my knowledge.

Signature of RN or Discharge Planner (circle one)

Date signed

Printed Name

Patient Authorization: I request payment of authorized Medicare, Medicaid or other insurance be made directly to the above ambulance service for any service/supplies rendered to me. I authorize release of medical information for billing purposes. I agree to pay SBVAS for any charges not covered by insurance, except where otherwise prohibited by law. I understand that prior authorization may be required for these transports and that if such authorization was not obtained, I assume full financial responsibility for all charges not paid by my insurance.

Signature of Patient, Spouse, or Guardian

Date signed