



ADDRESSOGRAPH / LABEL

Developing New Partnerships for Your Health and Safety

PHYSICIAN CERTIFICATION STATEMENT

A.	Date(s) of Service: (Maximum 60 days for repetitive transfers)
B.	Ambulance transportation is <input type="checkbox"/> one way or <input type="checkbox"/> round trip.
	Origin <i>(If facility, include its name, address, and discharge date if applicable)</i>
	Destination <i>(If facility, include its name, address, and admission date if applicable)</i>
	Was the destination the nearest appropriate facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(please explain if 'no')</i>
C.	<p>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 either be bed confined or suffer a condition such that transport by ambulance is medically required. To be bed confined, the patient must meet ALL of the following criteria:</p> <p style="text-align: center;">The patient must be unable to get up from bed without assistance AND The patient must be unable to ambulate AND The patient must be unable to sit in a chair or wheelchair.</p> <p style="text-align: center;">ALL THREE QUESTIONS BELOW MUST BE ANSWERED OR THIS PCS WILL BE CONSIDERED INVALID:</p> <p>1] Is this patient 'bed confined' as defined above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2] What medical or physical condition does the patient above present with ON THE DATE OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance?</p> <p>3] Can this patient be safely transported strapped in a wheelchair bolted to the floor unattended in the back of a moving wheelchair van? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
D.	<p>I certify that the above information is true and correct based on my evaluation of this patient, the best of my knowledge and professional training, and that this patient requires ambulance transport. I understand that this information will be used by the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to support the determination of medical necessity for ambulance services.</p> <p>_____</p> <p>Signature of Physician or Healthcare Professional Date</p> <p>_____</p> <p>Printed Name <i>(must be legible)</i></p> <p style="text-align: center;">If this form is signed by a healthcare professional <i>other than</i> a physician, please circle title of signer:</p> <p>Physician's Assistant Clinical Nurse Specialist Registered Nurse Nurse Practitioner Discharge Planner</p>

Please fax to (315) 462-6061 when scheduling the transfer and provide the ambulance crew with this original document. If you need assistance completing this form, please call our business office at (888) 462-5781. Thank You.