

FAX: 215.744.4565
PHONE: 215.744.4500



PHYSICIAN MEDICAL NECESSITY CERTIFICATION

For Non-Emergency Medical Transportation

Transport Date: _____/_____/_____ Certificate Expiration Date (Max 60 Days) _____/_____/_____
Patient's Name: _____ Medicare #: _____
Transported From: _____ Transported To: _____
Physician's Printed Name: _____ License # _____ (Optional)

Transport by Ambulance IS NECESSARY...

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means.

Is your patient bed-confined as defined by Medicare (HCFA) Regulation?

YES

The HCFA definition of Bed-Confinement is: Inability to get up from bed without assistance, ambulate, and sit in a chair, including wheelchair.

If you checked YES, the patient meets the requirement for Medical Necessity, PLEASE SIGN THE FORM BELOW.

NO

Please check the medical conditions below which would necessitate transport by ambulance and make all other means of transportation contraindicated

This patient:

- cannot support self safely while seated in a wheelchair
- is exhibiting signs of decreased level of consciousness
- requires continuous oxygen
- requires airway monitoring or suctioning

- has decubitus ulcers & requires wound precautions
- requires isolation precautions (VRE, MRSA, etc.)
- is on orthopedic precautions
- is able to tolerate a wheelchair but is medically unstable due to other conditions indicated on this form

OTHER (Explain)

Transport by Ambulance is NOT NECESSARY...

In my professional medical opinion, this patient does not require ambulance transportation and can be safely transported by other means. The patient's condition is such that transportation by ambulance is not required because the means listed below is safe and acceptable:

- Patient can safely support him/herself while seated in wheelchair and does not require monitoring by trained personnel.

**THE PATIENT DOES NOT MEET THE REQUIREMENTS FOR MEDICAL NECESSITY
PLEASE SIGN BELOW.**

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services, Health Care Financing Administration to support the determination of medical necessity for ambulance services.

Original Signature of Physician

_____/_____/_____
Date Signed

OR

*"If the ambulance supplier is unable to obtain the signed certification statement from the attending physician, a signed physician certification statement must be obtained from either the **PA, NP, CNS, RN, or discharge planner** who is employed by the hospital or facility where the beneficiary is being treated with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished..." [Per Xact Medicare Services clarification letter dated February 10, 2000].*

Signature of Authorized Healthcare Professional

_____/_____/_____
Date Signed