# Empress Ambulance Service / Emergacare NY Physician Certification Statement

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| **Pick up Location:** | **Phone:** | **Fax #** |
| **Destination:** | **Empress Ambulance Service Fax** | **914-965-9776** |

**Instructions:** **Medicare Part B pays for ambulance transportation only if other means of transportation would endanger the beneficiary's health (42 CFR Part 410 4 (d)(1)) This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance company to determine if Medical Necessity has been met. Please complete all sections on this form and sign the form prior to transport. The completed form should be faxed to Empress Ambulance @ 914-965-9776**

## Section 1 – BENEFICIARY INFORMATION

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| **Name:** | | | **Date of Service:** |
| **Sex** | **Date of Birth:** | **Other insurance:** | |
| **Medicare No:** | **Part B? ☐ Yes ☐ No** | | **Medicaid No:** |
| **Is the patient's stay covered under Medicare part A (PPS or DRG) benefits for this date of Service: ☐ Yes ☐ No** | | | |
| **Is this a round trip? ☐ Yes ☐ No** | **Standing order: From** ____ / ____ / ____ **To** ____ / ____ / ____ Mon ☐ Tues☐ Wed ☐ Thurs ☐ Fri ☐ Sat **(Valid for only 60 days)** | | |

## Section 2 – MEDICAL NECESSITY INFORMATION

**A patient is bed confined if he/she is unable to get up without assistance, unable to ambulate, & unable to sit in a wheelchair (must meet all 3). Based on this definition is the patient bed confined? ☐ Yes ☐ No**

**Supporting Diagnosis / Condition required for ambulance transportation: _____**

**Can this patient safely be transported in a car or wheelchair van (seated without medical monitoring?) ☐ Yes ☐ No**

**Please check any of the following conditions that apply. * Note supporting documentation for any boxes checked must be maintained in the patient's medical records***

- ☐ **Contractures** ☐ **Non healed fractures** ☐ **Moderate –severe pain on movement**
- ☐ **Cardio/hemodynamic monitoring** ☐ **IV meds/fluids required** ☐ **Ventilator required**
- ☐ **Third party assistance required to apply, administer, regulate, or adjust oxygen in route**
- ☐ **Isolation / special handling, describe _____**
- ☐ **Restraints (physical or chemical ) anticipated or used during transport**
- ☐ **Patient is confused, combative, lethargic or comatose**
- ☐ **Danger to self/others**
- ☐ **DVT requiring elevation of a lower extremity**
- ☐ **Orthopedic device requiring special handling during transport (ie: backboard, halo, use of pins in traction, etc.)**
- ☐ **Unable to maintain erect sitting position in a chair for time needed to transport**
- ☐ **Unable to sit in a wheelchair due to decubitus ulcers or other wounds**
- ☐ **Morbid obesity requiring additional personnel/equipment to safely handle patient**
- ☐ **Hemiparesis or Quadriplegia** ☐ **Medical attendant required**

**Other: _____**

## Section 3 – Physician's Authorization

**I certify that the information contained in section 2 above represents an accurate assessment of the beneficiary's medical condition(s) and that ambulance transportation is medically necessary. I also certify that our institution has furnished care or other services to the above-named patient in the past.**

**PRINT the name of Physician or Healthcare Professional: _____**

**SIGNATURE**: _____ **Date signed**: _____ / _____ / _____

**Forms must be signed only by patient's physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the forms may be signed by any of the following if the attending physician is unavailable. Please check one of the following:**

☐ **Physician** ☐ **Physician's Assistant** ☐ **Clinical Nurse Specialist** ☐ **Registered Nurse** ☐ **Nurse Practitioner** ☐ **Discharge Planner**