



**PROFESSIONAL  
AMBULANCE**  
and Oxygen Service Inc.

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**PHYSICIAN CERTIFICATION STATEMENT**

*The physician responsible for determining medical necessity of non-emergency ambulance service should complete this form. This form can also be completed and signed by an RN, PA, NP, CNS, or discharge planner who is employed by the hospital or facility where the patient is being treated, with knowledge of the patient's condition at the time of transport.*

**Patient name:** \_\_\_\_\_ **HIC#:** \_\_\_\_\_

Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is medically contraindicated by the patient's condition. The Centers for Medicare and Medicaid Services requires a physician or an appropriate representative of the facility where the patient is being treated to certify the medical necessity for such services.

**I certify that ambulance transportation is medically necessary as one or all of the following conditions apply:**

- Patient unable to get up from bed without assistance.
- Patient unable to ambulate.
- Patient unable to sit in a chair, including a wheelchair (could be moved only by stretcher).
- Transportation by medically trained personnel is required/Unsafe for patient to be unmonitored during transport.
- Patient requires oxygen.
- Patient under Section 12/restrained.
- Patient altered mental status (including CVA, dementia, OBS, Alzheimer's, head injury, coma, etc.).
- Patient requires Advanced Life Support services/availability. (cardiac monitor, IV maint., airway monitoring)
- Patient requires isolation precautions (VRE, MRSA, etc.)

**THIS PATIENT MEETS THE FOLLOWING TWO CONDITIONS FOR  
COVERAGE OF AMBULANCE TRANSPORTATION.**

- 1. USE OF OTHER METHODS OF TRANSPORTATION IS CONTRAINDICATED BY THE PATIENT'S CONDITION.**
- 2. AMBULANCE SERVICE IS MEDICALLY NECESSARY.**

**PLEASE LIST ADDITIONAL COMMENTS IF APPLICABLE:** \_\_\_\_\_

**I CERTIFY THAT THE PATIENT IS PHYSICALLY OR MENTALLY INCAPABLE OF SIGNING AN INSURANCE CLAIM FORM. I AM SIGNING ON THE PATIENT'S BEHALF AS A REPRESENTATIVE OF AN AGENCY OR INSTITUTION THAT DID NOT FURNISH THE SERVICES FOR WHICH PAYMENT IS CLAIMED BUT FURNISHED OTHER CARE, SERVICES, OR ASSISTANCE TO THE PATIENT. I UNDERSTAND THAT SIGNING ON BEHALF OF THE PATIENT IS NOT AN ACCEPTANCE OF FINANCIAL RESPONSIBILITY FOR THE AMBULANCE TRANSPORT.**

This physician certification statement is required for all non-emergency transports both scheduled and unscheduled. Non-emergency ambulance service is a Medicare service furnished to a patient for whom a physician is responsible; therefore, the physician is responsible for the medical necessity determination. If the decision to use ambulance services is based on the convenience of the patient, the patient's family, the patient's physician, or some other element of personal preference, Medicare coverage is not available.

**Physician/Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician/Staff Printed Name:** \_\_\_\_\_

This certification must be dated no earlier than sixty (60) days before the date of a non-emergency, scheduled ambulance service. This certification must be obtained before a claim for non-emergency unscheduled ambulance service can be submitted to Medicare.

**Professional Ambulance Provider # 021859 NPI-1568416279 Run #:** \_\_\_\_\_ **Date of Service:** \_\_\_\_/\_\_\_\_/\_\_\_\_