60 Day Physician Certification Statement

Please complete the following information and fax to 317-857-1481

Patients Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ *(Form must be signed by a physician **ONLY** to be valid for 60 days of scheduled repetitive trips)*

Closest appropriate facility? ☐ Yes ☐ NO If no why? _____

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 be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the physician signing below to be valid:**

1. Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance.

_____

_____

2. Bed Confined? ☐ Yes ☐ NO To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair.

3. ***In addition*** to completing questions 1 and 2 above, 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**
- ☐ **Patient is Comatose**
- ☐ **Moderate/severe pain on movement**
- ☐ **Need or possible need for restraints**
- ☐ **DVT requires elevation of lower extremity**
- ☐ **Isolation precautions required**
- ☐ **Unable to tolerate seated position for transport**
- ☐ **Non-healed fractures**
- ☐ **Danger to self or others/combative**
- ☐ **IV meds/fluids required**
- ☐ **Medical attendant required**
- ☐ **Requires Oxygen and unable to self-administer**
- ☐ **Hemodynamic monitoring required enroute**
- ☐ **Decubitus ulcers or other wounds**
- ☐ **Cardiac monitoring required enroute**
- ☐ **Morbid obesity-requires additional equipment/personnel to safely handle patient**
- ☐ **Orthopedic device (backboard, halo, pins traction, brace, wedge etc.) requiring special handling**
- ☐ **Other (specify) _____**

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time oftransport.

☐ **If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, *the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is asfollows*:**

_____ _____ _____

(Signature) **(Date)** **(NPI Number)**

_____ ☐ **MD** ☐ **DO**

(Printed Name of Physician ONLY)

Questions completing this form? 317-721-0346