PCS

TRI-MED AMBULANCE
Setting the Pace

Run # _____

Phone # (206) 988-5000

Fax # (206) 243-0756

(Physician's Certification Statement of Medical Necessity for Ambulance Transport)

Date of Transport:____/____/____
(Repetitive transports require a physician's signature: expires a maximum of 60 days after physician's signature)

Physician NPI#:

Physician Address:

Patient's Last Name: _____

Patient's First Name:_____MI: _____

Sex: (Circle One) M / F DOB:___/___/___SS#:_____

Medicare #:_____Medicaid #:_____

Authorization:_____

Transport From:	
Transport To:	
Primary Diagnosis:	
Secondary Diagnosis:	

Is the beneficiary BED CONFIN ED at the time of Transport? → Y☐ N☐
*Bed confined is defined by Medicare as the inability to get up from bed without assistance **and** the inability to ambulate **and** the inability to sit in a chair or wheelchair.*

1. The minimum safe level of transportation was or is:
   - ☐ BLS (Any means other than a fully equipped BLS ambulance could have endangered the patient's health.)
   - ☐ Critical Care (Any means other than a fully equipped ALS ambulance with minimum 1 RN & 1 EMT could have endangered the patient's health.)
2. Did the patient require positioning attained only by bed or stretcher? → Y☐ N☐
3. Other means of transport are contraindicated based on the following conditions requiring ambulance transport:

- ☐ Requires continuous oxygen (unable to self-administer)
- ☐ Requires airway monitoring
- ☐ Patient is ventilator dependent
- ☐ Requires EKG monitoring
- ☐ Has Continuously running intravenous devices
- ☐ Requires isolation precautions (VRE, MRSA, etc.)
- ☐ Cannot safely support themselves in a wheelchair
- ☐ Requires medical supervision during transport (explain below)
- ☐ Is comatose or obtunded, requiring trained monitoring
- ☐ Has decubitus ulcers and requires wound precautions
- ☐ Unable to get out of bed safely with one person assisting
- ☐ Other

Explain/ elaborate on conditions (not necessarily diagnoses) which necessitate ambulance transport:

I certify the above information represents an accurate assessment of the patient's medical condition(s). I understand the information will be used by the Health Care Finance Administration to help determine the Medical Necessity for ambulance service.

Signature:	Title: Date: / /
Print Name:	

☐ Physician ☐ Registered Nurse ☐ Discharge Planner
☐ Nurse Practitioner ☐ Physician Assistant ☐ Nurse Specialist