



Patient's Name: _____ Date of Service _____ Medicare No: _____

Origin: _____ Destination: _____

CERTIFICATION STATEMENT- ONLY TO BE COMPLETED BY MEDICAL FACILITY (REQUIRED BY 42 CR 410.40 (D) FOR ALL NON EMERGENCY TRANSPORTS). In my professional opinion, this patient requires transport by Ambulance. This patient's medical condition necessitates this level of care. Other means of transportation are contraindicated based on the patient's health and safety.

This patient is currently unable to get up from a bed without assistance, ambulate, and sit in a wheelchair secondary to:

- OR -

<p>Can not be transported safely in a wheelchair van due to:</p> <p><input type="checkbox"/> Unable to hold self in w/c due to: _____</p> <p><input type="checkbox"/> Unable to sit duration of transport due to: _____</p> <p><input type="checkbox"/> Overall wasting, too weak to sit up due to: _____</p> <p>Paralysis: <input type="checkbox"/>hemi <input type="checkbox"/> semi <input type="checkbox"/>quadriplegic</p> <p>Fracture of the:</p> <p><input type="checkbox"/>hip <input type="checkbox"/>neck <input type="checkbox"/>spine <input type="checkbox"/>knee <input type="checkbox"/>leg <input type="checkbox"/>Other _____</p> <p>Contractures of the: (circle R or L)</p> <p><input type="checkbox"/> Upper R / L <input type="checkbox"/> Lower R / L Extremity(s)</p> <p><input type="checkbox"/> Sever pain due to _____</p> <p><input type="checkbox"/> Abnormally stiff and rigid due to _____</p> <p>Decubitus ulcers of the:</p> <p><input type="checkbox"/>Sacrum <input type="checkbox"/>Buttocks <input type="checkbox"/>Coccyx <input type="checkbox"/>Hip <input type="checkbox"/>Lower Extremities</p> <p>Other: _____</p>	<p>Patient Requires Medical Monitoring:</p> <p><input type="checkbox"/> Airway/suctioning</p> <p><input type="checkbox"/> Vent Dependant</p> <p><input type="checkbox"/> Seizure precautions</p> <p><input type="checkbox"/> IV / Rx</p> <p><input type="checkbox"/> EKG</p> <p><input type="checkbox"/> Unable to self administer O2</p> <p><input type="checkbox"/> Altered level of consciousness</p> <p><input type="checkbox"/> Combative / Hostile</p> <p><input type="checkbox"/> Flight Risk</p> <p><input type="checkbox"/> Needs Restraints</p> <p><input type="checkbox"/> Isolation</p> <p><input type="checkbox"/> Other: Describe type of Monitoring and why: _____ _____</p>
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Additional Comments: _____

I certify the above information is true and correct based on my evaluation of this patient. I understand that the information contained herein shall be used by the Department of Health and Human Services/CMS to support the determination of medical necessity for Ambulance transportation. The execution of this document does not assure that any payment shall be made for services rendered to your patients

If this box is checked, I also certify the patient is physically or mentally incapable of signing the ambulance services claim and the institution 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). My signature does not constitute financial responsibility for ambulance services.

Print Name _____ Circle Title: MD PA NP RN DISCH PLANNER Signature _____ Date _____

Please Fax to 610-240-8631 or

Forward to: TransCare ML, 306 West Central Avenue, Paoli, PA 19301. Please feel free to contact us at 610-648-1648.