

Fraser Ambulance
Des Moines, Iowa
Phone: (515) 284-1111 / Fax: (515) 299-8905

Physician Certification Statement for Ambulance Transportation
(Required by attending physician for non-emergency ambulance transportation)

Section 1 – Patient Information

Patient's Name: _____ Transport Date: _____
Insurance #: _____ DOB: _____
Transport From: _____ Transport to: _____

SECTION 2 – Medical Necessity (Please check all of the following that apply)

- The undersigned does hereby certify that the above named patient;
 - Is unable to get up from bed without assistance, AND
 - Is unable to ambulate, AND
 - Is unable to sit in a chair or wheelchair (for duration of transport).

- The patient's medical condition is such that other means of transportation is contraindicated.

This patient:

- | | |
|--|---|
| <input type="checkbox"/> Requires airway monitoring or suctioning | <input type="checkbox"/> Has decubitus ulcers & requires wound precautions |
| <input type="checkbox"/> Patient is ventilator dependent | <input type="checkbox"/> Requires isolation precautions (VRE, MRSA, etc) |
| <input type="checkbox"/> Requires cardiac monitoring | <input type="checkbox"/> Requires restraints |
| <input type="checkbox"/> Requires iv maintenance | <input type="checkbox"/> Weight limits exceeds wheelchair safety limitations |
| <input type="checkbox"/> Is exhibiting signs of a decreased level of consciousness | <input type="checkbox"/> Comatose & requires trained monitoring |
| <input type="checkbox"/> Is seizure prone and requires trained monitoring | <input type="checkbox"/> Is potential risk to self and / or others. (Explain below) |
| <input type="checkbox"/> Other
(Explain) _____ | |
- _____
- _____

SECTION 3 – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

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 due to the reasons documented on this form. 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 that I have personal knowledge of the patient's condition at the time of transport.

Signature of Physician* or Healthcare Professional

Print Name of Physician* or Healthcare Professional

Date Signed

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)*

- | | | |
|--|--|---|
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Clinical Nurse Specialist | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Discharge Planner | <input type="checkbox"/> Licensed Practical Nurse |