Physician's Medical Necessity Certification

***For Non Emergency** Scheduled and Unscheduled Medical Transportation Services*

Transport Date: ___/___/____.   Certificate Expiration Date (Max 60 days) ___/___/___

(PMNC effective for 60 days for repetitive transports or for a single prescheduled or unscheduled transport only.)

Patient's Name: ____________________________________   Medicare #: ________________________

Transported From: ______________________________   Transported To: _______________________________

Physician's Printed Name: ____   License # or UPIN # _________

OPTION I

In my professional medical opinion this patient does not require transport by ambulance and can safely be transported by other means. The patient's condition is such that transportation by ambulance is not required because the means listed below is safe and acceptable:

O Patient can safely support him / herself while seated in wheelchair and does not require monitoring by Trained personnel.
O Patient is able to tolerate transportation by automobile or wheelchair van.

OR

OPTION 2

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required.

The HCFA definition of Bed-Confinement is: The inability to get up from bed without assistance; ambulate; and sit in a chair, including a wheelchair. (ALL MUST BE MET)

*** Is your patient bed-confined as defined by Medicare (HCFA) Regulation? ☐ Yes ☐ No**
*** If the patient does not meet bed-confined criteria as defined above, can this patient be safely transported by wheelchair van? ☐ Yes ☐ NO**
If NO please check the appropriate medical conditions listed, below which would necessitate transport by ambulance and make all other means of transportation contraindicated based on patient safety and health.

This patient: ** (A) - MUST *BE DEFINED IN OTHER* **

O requires continuous oxygen & monitoring by trained staff
O requires airway monitoring or suctioning
O requires restraints or sedation (A)
O comatose & requires trained monitoring
O is actively seizure prone & requires trained monitoring
O had to remain immobile because of a fracture/possibility of a fracture which had not been set
O patient is ventilator dependent
O contractures (A)
O Other
(Explain) ____

____

Q has advanced decubitus ulcers & requires wound precautions (A)
O requires isolation precautions (VRE, MRSA, etc.) (A)
O patient requires continuous IV therapy
O requires cardiac monitoring
O is exhibiting signs of a decreased level of consciousness(A)
O requires hip precautions and cannot sit safely
(A) (Hip fracture requires further explanation)
O is not wheelchair able (should not stand, pivot or ambulate or is unable to safely assist with moving themselves)

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FROM THIRD PARTY PAYERS SUCH AS THE MEDICARE PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, MAY BE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND/OR STATE LAWS.

____   ___/___/_____
Signature of Ordering Physician or Authorized Healthcare Professional   Date Signed