



AMERICAN MEDICAL RESPONSE

AMR Ventura County 1-800-404-1222

Patient Name: _____ D.O.B: _____

SSN: _____ Date of Transport: _____

Pick up at: _____ RM#: _____

Transport to: _____ RM#: _____

Excessive mileage: Was this the closest facility able to accommodate patient? | Yes [] No []

Why: _____

Physician Certification Statement (Medicare)

Ambulance transportation is medically necessary for the following reasons:

Diagnosis: _____

Bed Confined: _____

"Bed Confined" would be defined as the inability to get up from bed without assistance; inability to ambulate; and inability to sit in a chair or wheelchair. All Three Conditions Must Be Met.

Non-ambulatory due to: _____

Defined as the following criteria, could only be moved by stretcher. (Please check box that applies)

- [] Requires continuous oxygen [] Comatose and requires trained monitoring
[] Requires airway monitoring [] Seizure disorder (specify level of activity)
[] Ventilator Dependant [] Contractures require specialized handling unable to sit, "indicate site(s)"
[] Medicated and needs supervision [] Requires isolation precautions due to MRSA, etc.
[] Psychiatric Hold (indicate level 5150, 5250, etc.) [] Patient danger to Self
[] Danger to Others [] AWOL/Wandering risk [] Needs Restraints?

[] Special services/treatment required and not available at Sending Facility; specify services, procedures, equipment etc. Not Available at the Sending Facility: _____

[] No Beds available Was patient discharged from 1st facility [] YES [] NO

[] Requires Medical Supervision during transport (explain below)

Additional Information: Explain/Elaborate on the condition of the patient requiring ambulance transportation:

"By signing this form I am stating that I am a licensed physician, physician assistant, nurse practitioner case manager/discharge planner who performed professional services for the patient who's name appears on this Physician Certification Statement." ** I am stating that I am signing this statement under consultation with and oral orders from the attending physician.

**Auth. Signature _____ Title _____ Date: _____

Physician Signature _____ Date: _____

Physician Name _____ UPIN: _____

Telephone # _____

Medicare Manual 2120.2 :Necessity for the Service, is established when the patient's condition is that the use of any other means of transportation is contraindicated.

AMR must bill patient for all non-covered transports, including physician convenience, patient/family convenience and Dr's office visits.

Please give to AMR transport crew or Fax to: 805-517-2948 - Phone: 1-800-404-1222 (Rev. Jan 2006)