TEXAN EMS

Physician's Medical Necessity Certification

Complete for non-emergency ambulance transportation – scheduled or unscheduled

PHONE: (936) 327-9113 / FAX: (936) 327-9116

In order for ambulance services to be covered, they must be medically necessary and reasonable. This form provides the information needed to make medical necessity determinations for non-emergency ambulance transportation.

Beneficiary's Name: _____

Date of Birth: _____ **Date of Service** _____

SAME DAY RETURN under Medicare Part A Inpatient stay? ☐ **Yes** ☐ **No**

PLEASE CHECK ALL THAT APPLY:

☐ **Bed Confined** - The patient is: (all three conditions must apply), unable to get up from bed without assistance; ***and,*** unable to ambulate; ***and,*** unable to sit in a chair or wheelchair.

☐ **Lack of Coordination, Fall Risk or Unsteady Gait.**

☐ **Stretcher Only** - Other means of transportation are contraindicated because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience.

☐ **Psychiatric assistance and/or restraints due to patient and/or others safety: Alzheimer's, Disoriented, psychosis, schizophrenia, dementia, or psychiatric behavior.**

☐ **Requires Life Sustaining Device (Oxygen, Ventilator, Etc.)**

List condition(s) which necessitates the transport

PLEASE CHECK ALL THAT APPLY:

☐ **Altered Mental Status, Dementia, Alzheimer's**

☐ **Hemiplegic/Paralysis/Quadriplegic**

☐ **Contractures to LE / UE , Bent or 90 Degrees, Fetal**

☐ **Terminal and/or Debilitated Cancer**

☐ **Recent Fracture (Hip/Back/Femur)**

☐ **AKA / BKA (Right / Left / Bilateral)**

☐ **Unsteady Gait and/or Nonweight Bearing/Recent LE FXs**

☐ **Debilitated Physical Condition**

☐ **Recent CVA or late effects of CVA**

☐ **Recent Head Injury**

☐ **DECUBITUS (Stage III or Higher/Nonweight Bearing)**

☐ **Morbid Obesity** _____ **LBS**

☐ **Danger to self and/or others. Requires Restraints**

☐ **Requires life sustaining oxygen device.**

☐ **OTHER**

Any medical staff that falsely attests a prescribed ambulance transport, and knowingly or willfully makes or causes to be made false any statement or representation of material fact in any application for benefits or payments under the Medicare law shall be guilty of a misdemeanor. Conviction thereof may result in a fine, imprisonment, or both. A false attestation can result in civil monetary penalties and a fine of as much as $10,000.00 per item. For non-emergency ambulance transports, Medicare requires, in accordance with CFR 410.40, a Physician Certification Statement (PCS) from the patient's attending physician certifying that medical necessity requirements for ambulance transportation are met. If unable to obtain the PCS from attending physician, a PCS may be obtained from a RN, PA, NP, CNS, or Discharge Planner knowledgeable of the patient's condition(s). **THIS CERTIFICATE IS GOOD FOR 60 DAYS.**

AUTHORIZED SIGNATURE OF ATTESTATION:

Print Name: _____

Signature: _____ **DATE:** _____

I hereby certify that the stretcher was medically necessary.

SIGNER OF THIS DOCUMENT IS:

Attending Physician	☐	**Primary Physician**	☐
Registered Nurse (RN)	☐	**Discharge Planner**	☐
Nurse Practitioner (NP)	☐	**Clinical Nurse**	☐
Physician Assistance	☐	**Other:** _____	