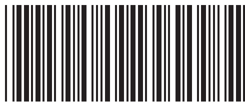
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AIR CARE & MOBILE CARE

513-584-CARE (2273) / 1-800-826-8100 / Fax: 513-585-5011

PHYSICIAN CERTIFICATION STATEMENT AMBULANCE

Inv # ________________

MR # ________________

Patient: ____ Date of Transport: ________________

Ambulance Medicare Provider #: 360003 Time of Transport: ________________

Patient Transported from: ____

Patient Transported to: ____

Description of medical necessity for transport: ____

____

Description of service(s) not available at referring facility which requires transport to another facility:

____

____

Check all appropriate items below:

Patient Is:

_____ Hospital admitted

_____ Hospital discharged

_____ Unable to ambulate, and

_____ Unable to get up with assistance, and

_____ Unable to sit in a chair or wheelchair

_____ Ventilator Dependent

_____ Other ________________________

_____ Other ________________________

_____ Other ________________________

Patient Requires:

_____ Continuous medical supervision enroute

_____ Emergency treatment

_____ Continuous cardiac monitoring

_____ Continuous IV infusion(s)

_____ Immobility

_____ Restraints

_____ Continuous oxygen administration enroute

_____ Continuous invasive pressure monitoring

_____ Other ________________________

The practitioner signing this form certifies ambulance transport is medically necessary and the patient is non-ambulatory at the time of transport as determined by the criteria above

Printed name and credentials: ________________________________

Signature: ________________________________

Authorized Practitioner
Physician
Discharge Planner
RN
Nurse Practitioner
Physician's Assistant
Clinical Nurse Specialist