*A service of Hamilton Hospital District* 204 S Ave M, Olney, Texas 76374 \* 940-564-5027 \* 940-564-5017 FAX

**Physician Certification Statement**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time Left Transferring Hospital: \_\_\_\_\_\_\_\_\_

Time Arriving Receiving Hosp: \_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transferring Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receiving Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Clinician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_ **Bed Confined** (at time of transfer)

**\*\*Unable to Sit, Stand, or Walk\*\***

*(All 3 conditions must apply both prior to and after transport to Qualify)*

\_\_\_Facility to Facility Transfer

*(What service is not available at the transferring facility?)*

\_\_\_Requires continuous **Oxygen Therapy**

\_\_\_Exhibits **Altered Mental Status**

\_\_\_Requires **Restraints**

\_\_\_Physical \_\_\_Chemical/Sedation

\_\_\_Patient is **Comatose**, Requires Monitoring

\_\_\_Patient is **Status Epilepticus**, Requires Monitoring

\_\_\_Unrepaired or **Recent Fracture/Joint Replacement**

**\*\*Must remain Immobile\*\***

\_\_\_Patient has severe **Contractures**

\_\_\_**Decubitus Ulcers**, Requires Wound Precautions

Stage \_\_\_ Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Requires **Isolation Precautions**

\_\_\_Requires **Mechanical Ventilation**

\_\_\_Requires Continuous **IV therapy**

\_\_\_Requires Continuous **Cardiac Monitoring**

\_\_\_Other **Advanced Treatment**:

Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Necessity Criteria

*(Please document all conditions that apply)*

*Medicare requires under 42 Cfr Part 401.40(d) that providers of ambulance transportation obtain a written statement from the patient’s attending physician certifying that medical necessity requirements for ambulance transportation are met for scheduled, non-scheduled, and non-emergency transports.*

1. This form must be completed in its entirety. If the physician is unavailable, this form may be completed by an employee of the physician or facility that is familiar with the patient’s condition.
2. Medical Necessity must be clearly documented according to CMS guidelines.
3. If the patient requires repetitive transports (3 or more within a 10 day period), this form must be signed by the physician prior to the first transport. This form will be valid for a 60-day period.