PHYSICIAN'S CERTIFICATION STATEMENT ©

FACILITY: _____ DATE OF SERVICE: _____ TEMS # _____

PATIENT NAME: _____ DOB: _____ FLOOR/ROOM #: _____

ATTENDING PHYSICIAN: _____ UPIN #: _____

Please answer the following questions concerning the above named patient we have been asked to transport.

1. Is this patient covered under Medicare? ☐ YES ☐ NO HIC No: _____ (if no, answer 2.)
2. Insurance Type: _____ ID Number: _____
3. Was Prior Authorization Required? ☐ YES ☐ NO If yes, Authorization Number: _____
4. Is this patient within PPS (part A covered) Period? ☐ YES ☐ NO If yes, Authorization Number: _____
5. Is this trip for a service covered by the current SNF Plan of Care? ☐ YES ☐ NO
6. What type of service is the patient being transported to the hospital (or other facility) to receive?

- ☐ Dialysis
- ☐ X-Ray, if so, what area(s)? _____
- ☐ MRI, if so, what area(s)? _____
- ☐ Is on hip precautions or rule out fracture and can not sit up
- ☐ Other diagnostic test, if so, what type? _____
- ☐ Radiation Therapy, if so, what area? _____
- ☐ Hyperbaric Oxygen Therapy or continuous monitoring
- ☐ Bed confined, has contractures, or has wound precautions
- ☐ Requires airway monitoring, suction or ventilator dependent
- ☐ Is comatose & requires trained monitoring
- ☐ Requires IV maintenance
- ☐ Requires restraints other than seat belts or sedation
- ☐ Tube Insertion/Reinsertion: _____
- ☐ CT Scan, if so what area? _____
- ☐ Cardiac Catheterization or Angioplasty
- ☐ Surgery, if so, what type? _____
- ☐ Lymphatic or Venous Procedures
- ☐
- ☐ Scheduled Clinic Visit _____
- ☐ Requires oxygen **(other than self-administered)**
- ☐ Requires cardiac EKG monitoring
- ☐ Requires isolation precautions
- ☐ Requires medical supervision during transport
- ☐ Is seizure prone requiring monitoring

This patient required transportation in an ambulance for the following medical reason (s) _____

_____

_____

Signature: _____

PHYSICIAN, PHYSICIAN ASSIST., NURSE PRACTIONER,CLINICAL NURSE SPECIAL.,REGISTERED NURSE , DISCHARGE PLANNER

Completed by: _____ _____ _____

(PRINT NAME) **TITLE** **DATE**

To comply with Federal and State Insurance regulations, it is essential that this form be completed and given to the EMS crew at the time the patient is picked up at your facility. If this trip was an emergency, and this form was not immediately available to be given to the EMS crew, it must be completed within 24 hours and faxed to (978) 441-2280.

If you have any questions pertaining to Billing, please do not hesitate to contact our Billing specialist at (978) 441-9191.