



Leon County Emergency Medical Services  
Physicians Certification Statement for Ambulance Transport  
**This form must be filled out for any transport from  
any facility, regardless of the patient's Medicare Status.**  
**FAX TO – (850)921-4100**

Medicare requires under 42 CFR part 410.40(d) that ambulance transport providers obtain a *Certificate of Medical Necessity* signed by the patient's physician or representatives noted below for the provision of non-emergency transportation. This form has been designated to assist the physician, the facility, the Medicare Beneficiary, and the ambulance provider to determine if Medical Necessity has been met and **MUST BE COMPLETED PRIOR TO ANY NON-EMERGENCY TRANSPORT\***. A copy of this form should be **faxed to (850)921-4100\*\***, in addition to calling to setup the transport. The original form should be given to the transporting crew. To setup a transport call 921-0900.

\*The ENTIRE form must be completed properly and legibly PRIOR to transport.

\*\*Non-Emergency transports will not be completed without a completed Physician Certification.

**Section 1 – Patient Information**

Patients Name \_\_\_\_\_ Transport Date \_\_\_\_\_ SSN \_\_\_\_\_

D.O.B. \_\_\_\_\_ Transport from \_\_\_\_\_ Rm \_\_\_\_\_ Destination \_\_\_\_\_ Rm \_\_\_\_\_

Physician Printed Name \_\_\_\_\_ Physician Office Fax # \_\_\_\_\_

**Section 2 – Medical Necessity (Check ALL that apply)**

The Undersigned does hereby certify that the above named patient

- is unable to get up from bed without assistance,
- is unable to ambulate, and
- is unable to sit in a chair or wheelchair (for duration of transport).

In addition, the patient's condition is such that any other means of transportation (such as a stretcher service) is contraindicated and this patient:

- |   |  |
|---|--|
| <input type="checkbox"/> requires continuous oxygen & monitoring by trained staff | <input type="checkbox"/> has decubitus ulcers & requires wound precautions                                       |
| <input type="checkbox"/> requires airway monitoring & suctioning                  | <input type="checkbox"/> requires restraints   |
| <input type="checkbox"/> is ventilator dependent                                  | <input type="checkbox"/> requires IV maintenance   |
| <input type="checkbox"/> requires cardiac monitoring                              | <input type="checkbox"/> Weight exceeds wheelchair or stretcher van safety limit. Pt's approximate weight: _____ |
| <input type="checkbox"/> requires isolation precautions (VRE, MRSA, etc.)         | <input type="checkbox"/> is comatose & requires trained monitoring   |
| <input type="checkbox"/> is exhibiting decreased level of consciousness           | <input type="checkbox"/> other (explain) _____   |
| <input type="checkbox"/> is seizure prone & requires trained monitoring           |  |

**Section 3 – Certification Signature**

Printed Name of Certifying Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Signature of Physician or Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

**NOTE:** If the patient does not meet any of the above criteria of medical necessity for ambulance transport then the transferring facility (by signature of the physician/facility representative) is accepting responsibility for all ambulance charges relating to the patients transfer. (Quoted Price of non-medically necessary transfer: \$787.00 + \$14.74/mile)