

Physician Certification Statement for EMS

MyMichigan Health

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Transport Date: _____

Patient's Name: _____

Medicare #: _____

Transported From: _____

Transported to: _____

Physician's Printed Name: _____

License # or UPIN: _____

In order for Ambulance Services to be covered, they must be medically necessary and reasonable. Medical necessity is established when **the patient's condition is such that transportation by any other means is contraindicated**. Please complete the questions below in order for the ambulance claim to be evaluated under Medicare coverage criteria.

1) Is the patient able to be safely transported by any means other than ambulance? Yes No If No, Please continue

The Health Care Financing Administration has defined "bed confinement" as (all three criteria must be met):

The patient is:

- Unable to get up from bed without assistance; and
- Unable to ambulate; and
- Unable to sit in a chair or wheelchair.

2) Is the patient bed-confined as defined above? Yes No

3) If No, please check the appropriate medical condition listed below.

This patient:

- | | |
|--|--|
| <input type="checkbox"/> Requires restraints to prevent harm and/or injury to self or others (explain) | <input type="checkbox"/> Had to remain immobile because of a fracture that had not been set or the possibility of a fracture |
| <input type="checkbox"/> Requires isolation precautions (explain) | <input type="checkbox"/> Contractures |
| <input type="checkbox"/> Requires cardiac monitoring | <input type="checkbox"/> Is ventilator dependent |
| <input type="checkbox"/> Has decubitus ulcers and requires wound precautions (explain) | <input type="checkbox"/> is exhibiting signs of a decreased level of consciousness (explain) |
| <input type="checkbox"/> Requires continuous oxygen monitoring by trained staff | <input type="checkbox"/> Requires continuous IV therapy |

Note: patients who are generally mobile with portable oxygen would not require non-emergency ambulance transportation based solely on the need for oxygen.

Other, please specify, or (explain): _____

I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical records of the patient.

Time: _____ Date: _____ Physician Signature: _____

Distribution: Original - Medical Record; 1st copy - EMS

Revised 5/5/2023



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Transfer Documentation