24-Hour Dispatch
713-785-6300
Fax: 713-785-6301

Physician Certification Statement

For MEDICARE and other insurance carriers who require a PHYSICIAN'S OVERVIEW and SIGNATURE as proof that this patient meets the requirements for need of stretcher transportation via AMBULANCE.

Patient must require transportation by ambulance and cannot be v by other means, such as wheelchair, taxicab, or private vehicle.

Printed Name of Physician _____ Date _____

Signature of M.D., P.A., R.N., R.N.P., C.N.S. or Discharge Planner (see PCS instructions) _____

Accepted Authorized Signature: For all scheduled and unscheduled transports, excluding, pre-arranged repetitive transports such as Dialysis, the Attending Physician, Clinical Nurse Specialist, Registered Nurse, Nurse Practitioner or Discharge Planner, who is employed by the transferring facility, and who has personal knowledge of the patient's condition at the time the transport is ordered, may sign the authorization.

Patient's Printed Name _____

Transferring Facility _____ ☐ Basic Nursing ☐ Hospital ☐ Skilled Nursing ☐ Other

Receiving Facility _____ ☐ Basic Nursing ☐ Hospital ☐ Skilled Nursing ☐ Other

♥ If transferring hospital to hospital, please state the services(s) transferring facility cannot provide:

_____

Select all that apply representing this patient's condition that requires stretcher transportation, and complete the supporting diagnosis or use other narrative that substantiates the selections below:

☐ Unable to sit in wheelchair for periods of time greater than 15 minutes
☐ Unable to stand and pivot, move from bed to chair, wheelchair, or seat of any type without full lift assistance
☐ Comatose or severely decreased level of consciousness
☐ Requires constant oxygen administration or portable ventilator: {no portable oxygen available}
☐ Requires monitoring of prescribed I.V. drug(s) via portable I.V. pump(s)
☐ ECG monitoring
☐ Requires airway care, suctioning and monitoring
☐ Requires physical restraining via leather, Posey or medication/sedation
☐ Debilitated or post operatively recovering, and is currently bedridden
☐ Chemically sedated and requires monitoring, unable to transport via wheelchair at this time
☐ Wound requiring wound precautions {i.e. Decubitus ulcer}
☐ Presents as bedridden due to paralysis or atrophy
☐ Post fracture requiring bed confinement

Supporting Diagnosis: _____

Other Narative: _____

If you should need help with patient evaluation or if you have questions about this form, please call direct to our insurance help line 713-785-6300.