425 Saint James Ave.
Springfield, MA 01109

NATIONAL AMBULANCE

Phone: 413-736-0092
Fax: 413-736-0079

PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY FOR **AMBULANCE** TRANSPORTATION

Starting Date:_____/_____/_____ **Ending Date**:_____/_____/_____

Patient's Name:_____ **DOB**:_____/_____/_____

Pick-Up Location:_____
Facility Street City State

Destination Location:_____
Facility Street City State

Attending Physician Name / Address_____

Ambulance Transportation is medically necessary for the following reason(s):

Chief Complaints: Check At Least One

__Obesity - Morbid 278.01

__Decubitus Ulcers 707.00

__Fatigue/Lethargic 780.79

__Amputation – Leg Bilat 897.6
Amputation – Leg Nos 897.4

__Gait Abnormality (Unsteady) 781.2

__Weakness – Muscle (General) 728.87

__Shortness of Breath 786.05
(Requires Oxygen)

__Fracture – Bone 829.0
*Explain Below

__Wound 879.6
*Explain Below

__Pain 780.96
*Explain Below

__Isolation/Precaution V07.0
MRSA, VRE, TB, HEP

__Psychosis (Unspecified) 298.8

__Suicidal Ideation V62.84

__Altered Mental Status 780.97

__Cerebrovascular Accident 434.91
CVA/Stroke

__Convulsions 780.39
Seizure Prone

__Coma 781.01

Secondary Complaints: Check All That Apply

__Ventilator Dependant 518.81
*MD signature required

__Cardiac EKG Monitoring 428.9
*MD signature required

__IV Therapy/Drug Administration
*MD signature required

__Airway Monitoring/Suctioning

__Oxygen Dependence V46.2

__Unable to transfer from bed to stretcher without medical assistance
*Explain Below

__Unable to sit safely upright during transport
*Explain Below

__Requires Medical Supervision
*Explain Below

__Bed Confined V49.84
*Explain Below
Unable to get up from bed without assistance;
Unable to ambulate; and
Unable to sit in a chair or wheelchair

__Violent, Combative or Confused

__Flight Risk: danger to self/others

__Restraints (Physical/Chemical)

__Hip Precaution/non-healing fracture

Other Condition or Reason for Requiring Transportation by Ambulance: _____

_____

_____

_____

Signature:_____
Form must be signed only by patient's attending physician for scheduled, repetitive transports and valid for 60 days from date above

Print Full Name:_____ **Please check appropriate designation below**:

_____MD –Physician _____DO-Physician _____Physician Assistant _____Nurse Practitioner

_____Registered Nurse _____Discharge Planner _____Clinical Nurse Specialist

I have reviewed the above certificate and I have determined (I have received and oral/written order from the attending physician) for the above named patient/beneficiary that ambulance transport and medical assistance/monitoring by EMT's is medically necessary for the reasons stated above. I further believe that other means of transportation whether available or not would be contraindicated, inadvisable and potentially injurious to this patient. I certify that the information contained herein is, to the best of my knowledge, complete and accurate and supported in the medical record of the patient.