Seals Ambulance Service

Physician Certification Statement

Please complete the following information
And fax to ***(317) 485-5290***

Please complete the following information and have the patients attending physician sign and date in the indicated spaces.

Beneficiary Information:

Name: _____ Transportation Date(s): _____
(Last Name) (First Name)

Sex: [ ] Male [ ] Female DOB [/ /] Age: [ ] Patients SSN: [_____]

Medicare Number: _____ Other Insurance: _____

Medical Necessity Information:

	This Patient:
[ ] requires continuous oxygen & trained monitoring	[ ] has decubitus ulcers & requires wound precautions
[ ] requires airway monitoring or suctioning	[ ] requires isolation precautions (VRE, MRSA, ect. .)
[ ] requires cardiac monitoring	[ ] is not wheelchair able (should not stand, pivot or ambulate)
[ ] is contractured and can not sit	
[ ] requires restraints	[ ] can not maintain balance sitting in a moving vehicle
[ ] comatose & requires trained monitoring	[ ] is exhibiting signs of decreased level of consciousness
[ ] is seizure prone & requires trained monitoring	[ ] requires IV maintenance
[ ] requires ventilator and/or assisted breathing	[ ] is not out of bed for more than 2 hours each day
[ ] other: (explain)	[ ] is an endangerment to self or others

_____

_____

_____

_____

Authorized Signer: (Must be a MD/DO, PA, NP, RN, CNS, Discharge Planner

_____

Signature **Date**

_____ [ ] MD/DO [ ] PA [ ] NP [ ] RN [ ] CNS [ ] Discharge Planner

Printed Name of Signer

The signature certifies that the information above represents an accurate assessment of the beneficiary's medical condition at the time of transport and that ***ambulance transportation is medically necessary*** and that transportation by any other means are contraindicated.