

# Seals Ambulance Service

## Physician Certification Statement

Please complete the following information  
And fax to (317) 354-8012

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

### **Beneficiary Information:**

Name: \_\_\_\_\_  
(Last Name) (First Name)

Transportation Date(s): \_\_\_\_\_

Sex: [ ] Male [ ] Female      DOB [ / / ]

Age: [ ]      Patients SSN: [ \_\_\_\_\_ ]

Medicare Number: \_\_\_\_\_

Other Insurance: \_\_\_\_\_

### **Medical Necessity Information:**

- requires continuous oxygen & trained monitoring
- requires airway monitoring or suctioning
- requires cardiac monitoring
- is contractured and can not sit
- requires restraints
- comatose & requires trained monitoring
- is seizure prone & requires trained monitoring
- requires ventilator and/or assisted breathing
- other: (explain)

### **This Patient:**

- has decubitus ulcers & requires wound precautions
- requires isolation precautions (VRE, MRSA, ect. . )
- is not wheelchair able (should not stand, pivot or ambulate)
- can not maintain balance sitting in a moving vehicle
- is exhibiting signs of decreased level of consciousness
- requires IV maintenance
- is not out of bed for more than 2 hours each day
- is an endangerment to self or others

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### **Physician's Authorization:**

Physician's Signature/or authorized personnel

Date

Physician name (printed)

License or UPIN

The Physician's 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*.