P.O. Box 776 • Mokena, IL 60448
Phone 847.963.8700 • Fax 708.478.8653

PHYSICIAN'S CERTIFICATION STATEMENT

Recertification required every 60 days

Date of Service: ____________________ Patient's Medicare Number: _________________

Patient's Name: ____

When a patient's condition is such that the use of any other method of transportation would endanger the patient, an ambulance transport may be covered by Medicare Part B. Describe the patient's medical condition that requires an ambulance transport:

____

____

____

Describe the patient's mobility limitations:

1. Could only be transported by stretcher because of the inability to sit safely for a sufficient time (over 30 minutes). (Examples: History of stroke with residual paralysis and inability to sit up in a wheelchair; amputation of lower extremity.) Describe:

   ____

   ____

   ____

2. What other medical condition(s) exist? (Examples: Need for oxygen therapy; IV fluids running continuously; need for immobilizer inhibiting sitting position.) Optional:

   ____

   ____

   ____

I certify that I am employed by the facility where the beneficiary is / was being treated and that I have knowledge of the beneficiary's condition at the time of transport.

☐ PA ☐RN ☐ NP

Signature: ______________________________________ ☐ Discharge Planner ☐ CNS

Date patient last examined by you: __________________

Physician Signature: ______________________________ Date: ____________________

Ancillary Hospital Representative: ___________________ Date: ____________________

Print or stamp: ___________________________________