LifeMed Alaska Physician Certification Statement

SECTION I – GENERAL INFORMATION

May be completed by LifeMed Alaska crew member.

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in a 60-day range as noted below)

Origin: _____ Destination: _____

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

Describe services needed at receiving facility not available at referring facility: _____

If hospice patient, is this transport related to patients's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Cannot be completed by LifeMed Alaska crew member. Must be completed by medical professional signing Section III.

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition.

The following questions must be answered by the medical professional signing below for this form to be valid:

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

2) To be "bed confined" the patient must satisfy all three of the following conditions:
   (1) *Unable* to get up from bed without assistance; AND
   (2) *Unable* to ambulate; AND
   (3) *Unable* to sit in a chair or wheelchair.
   Is this patient "bed confined"? ☐ Yes ☐ No

3) Can this patient safely be transported by car or wheelchair van, or commercial airline flight (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) Check any of the following conditions that apply (patient's medical records must support any boxes checked):

Acuity:
☐ Requires oxygen – unable to self-administer ☐ IV meds/fluids required
☐ Cardiac monitoring required en route ☐ Patient is comatose
☐ Hemodynamic monitoring required en route

Special positioning or handling:
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Non-healed fractures ☐ Contractures ☐ DVT requires elevation of a lower extremity
☐ Moderate/severe pain on movement ☐ Unable to tolerate seated position for time needed to transport
☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

Safety:
☐ Patient is confused ☐ Special handling/isolation/infection control precautions required
☐ Patient is combative ☐ Danger to self/others ☐ Need or possible need for restraints
☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ **Other** (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

If an attending physician is unavailable, any of the following may sign (check appropriate box):

☐ Physician Assistant ☐ Registered Nurse ☐ Clinical Nurse Specialist ☐ Social Worker
☐ Nurse Practitioner ☐ Licensed Practical Nurse ☐ Discharge Planner ☐ Case Manager
☐ This transport originated at a facility or scene where no person with any of the above credentials was available. No Signature is Required.

_____ _____
Printed Name of Physician or Healthcare Professional *Credentials (MD, DO, RN, etc.)*

_____ _____
Signature of Physician or Healthcare Professional Date Signed

☐ **If this box is checked,** I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____

LifeMed Alaska Assignment of Benefits Signature Form and Receipt of Notice of Privacy Practices

Patient Name: _____ **Transport Date:** _____

Privacy Practices Acknowledgment: By signing below, the signer acknowledges that LifeMed Alaska provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient.

X_____

SECTION I - PATIENT SIGNATURE

The patient must sign here unless the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in this section.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by LifeMed Alaska now, in the past, or in the future, until such time as I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by LifeMed Alaska, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. I agree to immediately remit to LifeMed Alaska any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to LifeMed Alaska. I authorize LifeMed Alaska to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to LifeMed Alaska and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by LifeMed Alaska, now, in the past, or in the future. I also authorize LifeMed Alaska to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

X _____ _____ X _____ _____
Patient Signature or Mark | Date | Witness Signature | Date

_____
Witness Address ☐ LifeMed Alaska Crewmember, address on file

SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.
NOTE: if the patient is a minor, the parent or legal guardian should sign in Section I.

On the line below, explain the circumstances that make it impractical for the patient to sign:

_____

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payor for any services provided to the patient by LifeMed Alaska, now, in the past, or in the future. By signing, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- ☐ Patient's legal guardian *(note: parent or legal guardian of a minor patient sign in Section I)*
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X _____ _____ _____
Representative Signature | Date | Printed Name and Address of Representative

SECTION III - AMBULANCE CREW SIGNATURE

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, **and**
(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)

My signature below indicates that, at the time of service, the patient named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by LifeMed Alaska, now, in the past, or in the future. **My signature is not an acceptance of financial responsibility for the services rendered.**

Explain the circumstances that make it impractical for the patient to sign: _____

Name and Location of Receiving Facility: _____ Time at Receiving Facility: _____

X _____ _____ _____ _____
Signature of Crewmember | Date | Printed Name of Crewmember | Credentials

RECEIVING FACILITY REPRESENTATIVE SIGNATURE

Complete this section for **ALL** transports

The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered to this patient.**

X _____ _____ _____ _____
Signature of Receiving Facility Rep | Date | Printed Name of Receiving Facility Rep | Credentials

*** A copy of this form is valid as an original ***