Physician Certification Statement

Northern Dutchess Paramedics
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www.ndpems.com

Date of Service: _____ / _____ / _____

Patient's Name: _____

DOB: _____ / _____ / _____ SSN: _____ - _____ - _____

Medicare #: _____ - _____ (Attach Face Sheet if Possible)

Medicaid #: _____ County: _____ PA# _____

Requesting Facility: _____ Room #: _____

Person Requesting: _____ Phone #: _____

Ordering Doctor: _____

Destination Facility: _____ Room #: _____

Accepting Doctor: _____ Phone #: _____

CERTIFICATION STATEMENT:
I understand the information listed on the back of this form is accurate based on my evaluation of the patient listed above. The information shall be used by the NYS DOH, Medicare, Medicaid and other insurance companies to determine medical necessity for ambulance transportation. As the patient's physician I verify that this mode of transportation is appropriate for the patient condition. If this patient was to be transported by other means it might compromise the patient's health and safety. **(The signature does not mean payment will be made by your facility if insurance does not cover.)**

Print Name: _____

Signature: _____

Title: MD: ___ PA: ___ NP: ___ RN: ___ Discharge Planner: ___ CNS ____

Date: _____ / _____ / _____ Time: _____

Attestation Statement for PCS Signatures

Name of Beneficiary: _____ Medicare Number: _____

"I _____ **(print full name of physician/practitioner that signed the PCS)** Hereby attest that the document dated _____, **(insert date of document)** accurately reflects signatures/ notations that I made in my capacity as _____ **(insert provider credentials, e.g. MD, RN, DO etc.)** when I certified the above listed Medicare beneficiary required ambulance transport. I do hereby attest that this information is true, accurate, and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability,"

_____ _____ _____
Signature Printed Name Date

NDP EMS - MISSION STATEMENT

TO PROVIDE MEDICAL TRANSPORTATION OF THE HIGHEST QUALITY, RESPONSIVE TO THE NEEDS OF THOSE WHO WE SERVE, AND TO PROVIDE SUCH SERVICES RELIABLY, WITHOUT BIAS AND IN A PROFESSIONAL AND COMPASSIONATE MANNER.

❑ **This patient is currently Bed-Confined per Medicare / CMS regulations**

Definition of Bed-Confinement – The inability to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair for duration of transport.

The patient is bed-confined due to: _____

❑ **Transport via Basic Life Support Ambulance (Please check appropriate boxes below)**
❑ **Transport via Advance Life Support Ambulance (Please check appropriate boxes below)**

Patient Requires the Following during transport:

❑ **Oxygen / Airway Management (Unable to self-administer)**
____ - NRB ____ - Nasal ____ - Venti Mask ____ - Re-breather Mask

_____ - Liters per Min / Percentage

❑ **Cardiac Monitoring / EKG**
❑ **IV / Medication** **Fluid: _____ @ _____cc / HR**

Fluid: _____ @ _____cc / HR

❑ **Ventilator** **Breaths per Min: _____ Tidal Volume: _____**
❑ **Altered Level of Consciousness / Dementia / Alzheimer**
❑ **Airway / Suction Required / Trach with Deep Suction**
❑ **Flight Risk / Needs Restraints / Orders for Restraints: _____ - Yes / _____ - No**
❑ **Isolation**
❑ **Need Constant Medical Supervision / Why: _____**

❑ **Other: _____**

_____

Does the Patient have any of the following conditions so they cannot be transported in a wheelchair:

❑ **Unable to sit in wheelchair for transport**
❑ **Unable to hold himself/herself up in wheelchair**
❑ **Paralysis:**
  ❑ **Hemi**
  ❑ **Semi**
  ❑ **Quadriplegic**
❑ **Fractures (Please note where: _____)**

❑ **Contractures (Please note where: _____)**

❑ **Bariatric Stretcher Required / Approximate Weight: _____ Height: _____**

❑ **Is this facility the closest appropriate facility for the patient's condition ___Yes____No**

If No, Please Explain: _____

_____

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

Privacy Practice Acknowledgment: by signing below, the signer acknowledges that NDP EMS provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. *A copy of this form is valid as an original*

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 for payment to Medicare, Medicaid, or any other payor for any services provided to me by NDP EMS now, in the past, or in the future. I understand that I am financially responsible for the services and supplies provided to me by NDP EMS, 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 NDP EMS any payment 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 NDP EMS. I authorize NDP EMS to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or other relevant documentation about me to release such information to NDP EMS and its billing agents, the Centers for Medicare and Medicaid Services and/or any other payors 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 NDP EMS, now, in the past, or in the future.

If the patient signs with an "X" or other mark, a witness should sign below

X_____ _____ _____ _____

Patient Signature or Mark | Date | Witness Signature | Date

Section II-AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **ONLY** if the patient is physically or mentally incapable of signing.

NOTE: The section must be completed **by the authorized representative**

The patient is physically or mentally incapable of signing because of the following reason(s):

_____

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 NDP EMS now, in the past, or in the future. I acknowledge that I am one of the following individuals: (1) patient's legal guardian; (2) patient's healthcare power of attorney; (3) a relative or other person who receives government benefits on behalf of the patient; (4) a relative or other person who arranges treatment or handles the patient's affairs; and/or (5) representative of an agency or institution that furnished care, services, or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____

Representative Signature | Date | Printed Name and Address of Representative

SECTION III: AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

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,

A. Ambulance Crew Member Statement (must) be completed by crew members 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 was available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for services rendered.**

Reason patient incapable of signing: _____

Name and Location of Receiving Facility: _____ **Time @ receiving Facility**_____

X_____ _____ _____

Signature of Crew Member | Date | Printed Name of Crew Member

B. Receiving Facility Representative Signature

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

X_____ _____ _____

Signature of Receiving Facility Representative | Date | Printed Name and Title of Receiving Facility Rep