OKLAHOMA
Health Care Authority

PHYSICIAN'S CERTIFICATION STATEMENT

FOR MEDICAL TRANSPORTATION MEMBER

Member Name: _____ **RID:** _____

Date of Transfer: _____

Ordering Provider: _____ **Provider ID or NPI #:** _____

Originating Facility: _____ **Provider ID or NPI #:** _____

Contact Person for Ordering Provider: _____ **Contact Person #:** _____

Accepting Facility: _____ **Provider ID or NPI #:** _____

Member DX: _____

Member Age: _____ **Member Weight:** _____

TYPE OF TRANSPORTATION REQUESTED:

Ground Ambulance ○ **Fixed Wing Air Ambulance** ○ **Rotary Air Transportation** ○

PATIENT AMBULATORY STATUS:

1. **Can patient sit up in a chair? Yes** ○ **No** ○
2. **If yes, how much time can the patient tolerate sitting up?** _____
3. **If no, what movement limitations prevent member from getting out of bed?**

   _____
4. **What illness created the movement limitations?** _____

PATIENT AIRWAY STATUS:

1. **Does the member have patent airway? Yes** ○ **No** ○
2. **Does the member require O2? Yes** ○ **No** ○
   - **A. Continuously** ○ **Intermittently** ○
3. **Is the member ventilator dependent? Yes** ○ **No** ○

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OTHER:

1. **Are there other conditions that could be affected, that would cause an adverse reaction to the member, if the request mode of transportation is not received? Yes ○ No ○**
2. **If yes, what condition and what adverse reaction might be expected?**

_____

REASON FOR AMBULANCE TRANSFER:

1. **Higher level of care? Yes ○ No ○**
   A. **If yes, type of care needed:** _____
2. **Transfer member to Oklahoma hospital? Yes ○ No ○**

TRANSPORT:

1. **Will there be a need for any type of special transport team? (NICU, ALS, etc.) Yes ○ No ○**
2. **Will a guardian or medical escort travel with the member? Yes ○ No ○**
3. **Do you have a transportation provider who is willing/able to transport member?Yes No ○ ○**
4. **If yes,**
   A. **Name of transportation provider:** _____
   B. **NPI for transportation provider:** _____
   C. **Contact name for transportation provider:** _____
5. **Is this request for transportation related to patient having to be transported out of Oklahoma for care? Yes ○ No ○**
6. **If yes, please refer to form HCA-65 to complete a request for Prior Authorization for out-of-state care.**

By signing below, the ordering provider affirms that the information provided in this form is correct and that the use of any other method of transportation is contraindicated.

Ordering Provider's Signature: _____ **Date:** _____

****This form must be signed by a Physician, NP or PA****
Fax: ***405-213-1145***

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/OHCA
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767