Physician Certification Statement (PCS)

Date of Service _____

Interfacility Ambulance Transportation

Transporting Agency - _____ Report# _____

First Name _____ Last Name_____

Date of Birth _____ Age _____ Pt weight _____

Patient transported from _____

Patient transported to _____

Medicare guidelines state, ambulance transportation would be covered when the patient's condition is such that use of any other method of transportation is contraindicated. If other modes of transportation could have been used without dangering the patient's health, then benefits cannot be paid for ambulance services. This form in itself does not establish medical necessity or guarantee payment for Medicare coverage of ambulance transportation. In such event, your facility may be held responsible for payment of the services rendered.

Medical Necessity Qualifying Documentation

Qualifying documentation supporting reasons that transport by any other means than ambulance is contraindicated. **Supporting documentation for any boxes checked must be maintained in the patient's medical records.**

Check ALL that apply:

☐ Bed confined (All three must be met to qualify for bed confinement)

(1) Unable to ambulate
(2) Unable to get out of bed without assistance
(3) Unable to safely sit up in a wheelchair

☑ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning

☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus on Buttocks, Sacral, Back or Hip

☐ Third party assistance /attendant required to apply, administer, or regulate or adjust oxygen en route

☐ IV medications/fluids required during transport

☐ Cardiac/hemodynamic monitoring required during transport

☐ Special handling en route – isolation

☐ Contractures

☐ Non-Healed fractures

☐ Moderate to severe pain on movement

☐ DVT requires elevation of lower extremity

☐ Morbid obesity requires additional personnel/equipment to handle

☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transport

☑ Severe muscular weakness and de-conditioned state precludes physical activity

☐ Restraints (physical or chemical) anticipated or used during transport

☐ Danger to self or others

☐ Risk of falling out of wheelchair or stretcher while in motion (not related to obesity)

☐ Confused, combative, lethargic, comatose

☐ Requires airway monitoring and suction during transport

SIGNATURE OF 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 due to the reasons documented on this form. 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 have personal knowledge of the patient's condition at the time of transport.

_____ _____ _____

Signature of healthcare professional Printed name Date signed

☐Physician Assistant ☐Clinical Nurse Specialist ☐Registered Nurse ☐Nurse Practitioner ☐Discharge Planner ☐MD/DO