PHYSICIAN CERTIFICATION STATEMENT (PCS)

MEDICAL NECESSITY for Non-Emergency Ambulance Transportation

I. 1. Transport Date:_________________ 2. Origin:_________________ 3. Floor/Unit:_________________
   4. Destination: __________________________________________________

   Complete by explaining reason(s) why patient requires non-emergency ambulance services.

II. Patient is unable to sit or travel in a wheelchair due to:
   8. ________________________________________________________________

   9. □ Monitoring/treatment is required during transport.
      (Please check off and explain in detail any of the following that would support the ambulance transport)
      10. □ Ventilator dependent (Please explain below)
      11. □ IV medications required en route (Please explain below)
      12. □ ECG monitoring required en route (Please explain below)
      13. □ Requires assistance to administer oxygen en route: (Please explain below)
      14. □ Requires suctioning /airway control en route: (Please explain below)
      15. □ Psychiatric Hold  □ Requires restraints  □ Flight Risk
      16. □ Risk of falling out of a wheelchair in motion due to: (Please explain below)
      17. □ Isolation Precautions due to: (Please explain below)
      18. □ Orthopedic Device that prevents transport by wheelchair or other means: (Please explain below)
      19. ________________________________________________________________

III. 20. What special services/treatments are not available at sending facility? (Hospital to Hospital only)
       □ Services not available: ____________________________________________
       Was patient discharged from sending facility? □ Yes  □ No

IV. 21. Signature Requirements:
       I certify that I am familiar with the patient’s condition and have determined that the patient’s medical record
       supports the ambulance transportation for the reason(s) specified. Ambulance service is hereby ordered.

       **For Repetitive Patients, a physician’s signature is required on a special 60 day certification**
       Please contact the above agency to schedule an Assessment and for the 60 day form.
       Please check your credentials below and Print and Sign your name:
       □ Physician  □ RN  □ Discharge Planner  □ NP  □ PA  □ CNS

       Print Name ____________________________ Signature ____________________________ Date ____________

Physician Certification Statement Pursuant to CFR [Section 410.40 (d) (2-3)]
Please Note: Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is contraindicated by the patient’s condition. The Centers for Medicare and Medicaid Services requires documentation of the medical necessity for such services.

Providing medical information on this form is not a HIPAA violation. It is required by Medicare and Medicaid for payment of service. If the form is not filled out entirely as stated below, it may result in non-payment of services.

I. This section is essential transport and patient demographic information.

<table>
<thead>
<tr>
<th>Field</th>
<th>How Field Should Be Completed</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Transport Date</td>
<td>MM/DD/YYYY</td>
<td>Day of Transport</td>
</tr>
<tr>
<td>2 Origin</td>
<td>ABC Hospital/Convalescent</td>
<td></td>
</tr>
<tr>
<td>3 Floor/Unit</td>
<td>Medical Floor/123a</td>
<td>Floor/Unit # pt is currently located</td>
</tr>
<tr>
<td>4 Destination</td>
<td>ABC Hospital</td>
<td>Facility patient is being transported to</td>
</tr>
<tr>
<td>5 Physician Name</td>
<td>Dr. John Doe</td>
<td>Physician that is requesting Transport</td>
</tr>
<tr>
<td>6 Phone</td>
<td>(555)555-1234</td>
<td>Phone/extension of physician</td>
</tr>
<tr>
<td>7 Fax</td>
<td>(555)555-1234</td>
<td>Fax physician can receive faxes on</td>
</tr>
</tbody>
</table>

II. Patient is unable to sit or travel in a wheelchair due to: This section requires a narrative explanation of why the patient needs an ambulance transport. Diagnosis(s) and description of patient’s condition is required. (“Deconditioned”, “Weak”, or “Psychiatric” are not acceptable reasons according to Medicare.)

9. □ Monitoring/treatment is required during transport.
   (If any of the following treatment is needed, please check off and use Line 10 notes to explain how the treatment would support the ambulance transport)

<table>
<thead>
<tr>
<th>Field (check if applicable)</th>
<th>Information to be included on the lines below</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Ventilator dependent</td>
<td>What condition causes the patient to be ventilator dependent</td>
</tr>
<tr>
<td>11 IV medications required</td>
<td>Please list the medications the patient will require enroute</td>
</tr>
<tr>
<td>12 ECG monitoring</td>
<td>Please list what condition necessitates the ECG monitor</td>
</tr>
<tr>
<td>13 Requires assistance to administer oxygen</td>
<td>Please list what condition precludes the patient from administering his/her own oxygen</td>
</tr>
<tr>
<td>14 Requires suctioning /airway control</td>
<td>Please list what condition that necessitates the suctioning/airway control</td>
</tr>
<tr>
<td>15 Psychiatric Hold</td>
<td>Please indicate to the right if the patient requires restraints or is a Flight Risk</td>
</tr>
<tr>
<td>16 Risk of falling out of a wheelchair in motion</td>
<td>Please explain what condition causes the patient to be unable to travel in a wheelchair</td>
</tr>
<tr>
<td>17 Isolation Precautions</td>
<td>Please list the conditions that warrant isolation precautions</td>
</tr>
<tr>
<td>18 Orthopedic Device</td>
<td>Please list the condition that requires the patient to utilize an orthopedic device and what that device is</td>
</tr>
</tbody>
</table>
**Section II continued:**

19. These lines should be utilized to explain any of the treatment checked above or, if none of the boxes are applicable, these lines should be used to explain the patient’s condition that requires ambulance transport. Items may include but are not limited to:

- Dementia – Please explain the patient’s deficits that would preclude other means of transport;
- CVA with deficits – May include paralysis or hemi paresis
- Contractures – Please explain the extent of the contractures (i.e. all extremities or limited to one)
- Fractures – Some fractures that require an ambulance may not require an Orthopedic Device. If this is the case, please explain the location of the fracture and the reason an ambulance may be needed
- Psychiatric diagnosis, explanation of the patient’s condition/mental status and reason for ambulance transfer must be on the PCS form even when there is a Petition and Cert.
- Any other condition that you may deem necessitates ambulance transport – Please be very specific with other conditions as to justify the need for an ambulance

**III. 20. What special services/treatments were needed and not available at sending facility?**

(Hospital to Hospital only)

□ Services not available:

Please list the service not available at the originating facility

Was patient discharged from sending facility? □ Yes □ No

Please check appropriate yes or no box

**IV. 21. Signature Requirements:**

I certify that I am familiar with the patient’s condition and have determined that the patient’s medical record supports the ambulance transportation for the reason(s) specified. Ambulance service is hereby ordered.

**For Repetitive Patients, a physician’s signature is required on a special 60 day certification**

Please contact the AMR Grand Rapids Business office (616) 459-8228 to schedule an Assessment and for the 60 day form.

Please check your credentials below and Print and Sign your name:

<table>
<thead>
<tr>
<th>□</th>
<th>Physician</th>
<th>□</th>
<th>RN</th>
<th>□</th>
<th>Discharge Planner</th>
<th>□</th>
<th>NP</th>
<th>□</th>
<th>PA</th>
<th>□</th>
<th>CNS</th>
</tr>
</thead>
</table>

| Print Name | Signature | Date |

**Physician Certification Statement Pursuant to CFR [Section 410.40 (d) (2-3)]**

Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is contraindicated by the patient’s condition. The Centers for Medicare and Medicaid Services requires documentation of the medical necessity for such services.

- Check the appropriate box for your title
- Print name
- Physicians indicate MD or DO
- Add signature & date