

**AMBULANCE TRANSPORTATION
PHYSICIAN CERTIFICATION STATEMENT FOR MEDICAL NECESSITY**

A Physician Certification Statement (PCS) is required, pursuant to 42 C.F.R. 410.40(d) (2) and (3), by the Centers for Medicare and Medicaid (CMS) on all scheduled and unscheduled non-emergency transports. (Please see below for signature requirements)

***Sections 1 - 4 MUST be completed in order for the form to be compliant with state and federal billing regulations.**

Section 1	PATIENT NAME:		DOB:	MEDICARE/MEDICAID ID:		
	TRANSPORTED FROM:		TRANSPORTED TO:		ROUND TRIP? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	TYPE OF TRANSPORT: <input type="checkbox"/> ALS <input type="checkbox"/> BLS		FREQUENCY OF TRANSPORT:	TYPE OF ONGOING TREATMENT:		
	DATE(S) OF SERVICE:	ORDERING PHYSICIAN'S PRINTED NAME:			ORDERING PHYSICIAN'S NPI:	

Section 2	PLEASE PROVIDE DOCUMENTATION OF THE PATIENT'S <u>MEDICAL CONDITION AT THE TIME OF TRANSPORT TO SUBSTANTIATE AMBULANCE MEDICAL NECESSITY.</u>	
	<ul style="list-style-type: none"> <input type="checkbox"/> Paralysis: Hemi _____ Quad _____ Para _____ <input type="checkbox"/> Unstable fractures <input type="checkbox"/> Contractures: Upper _____ Lower _____ Both _____ <input type="checkbox"/> DVT requires elevation of a lower extremity <input type="checkbox"/> Moderate/severe pain on movement <input type="checkbox"/> Restraints (physical or chemical) anticipated or used during transport <input type="checkbox"/> Dementia <input type="checkbox"/> Intermittent Confusion <input type="checkbox"/> Persistent Confusion <input type="checkbox"/> Patient is confused, combative, lethargic, or comatose. <input type="checkbox"/> IV meds/fluids required: _____ <input type="checkbox"/> Ventilator Required <input type="checkbox"/> Cardiac/hemodynamic monitoring required enroute <input type="checkbox"/> Chest Tube <input type="checkbox"/> Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling <input type="checkbox"/> Morbid obesity requires additional personnel/equipment to safely handle patient <input type="checkbox"/> Assistance/attendant required to apply, administer or regulate oxygen enroute 	<p align="center">Common ED Reasons:</p> <p><input type="checkbox"/> Higher Level of Care: <i>(list the reason)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Acute MI <input type="checkbox"/> ICB <input type="checkbox"/> Stroke <input type="checkbox"/> Multiple trauma, (list injuries): _____ <p><input type="checkbox"/> Specialty Care: <i>(list the reason)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Danger to self or others <input type="checkbox"/> Psychiatric Dx: _____ <input type="checkbox"/> Elopement Precautions <input type="checkbox"/> Peds: _____ <input type="checkbox"/> Other: _____
Other: _____		

Section 3	<u>All three criteria</u> below must be met to qualify for "bed confinement".	
	<ol style="list-style-type: none"> 1. Is the patient unable to ambulate? <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Is the patient unable to get out of bed without assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO 3. Is the patient unable to safely sit up in a wheelchair? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>*if YES, complete 3-A. & 3-B.</i> <ul style="list-style-type: none"> <input type="checkbox"/> a. Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning. <input type="checkbox"/> b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers. buttocks _____ coccyx _____ hip _____ other _____ 	<p>Is the patient bed confined? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please check or list the condition resulting in bed confinement above in section 2.</p>

Section 4	Physician Certification / Authorization: I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.	
	Printed Name W/Credentials:	
	Title: <input type="checkbox"/> Attending Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Discharge Planner	
Authorized Signature:		Date Signed:

Medicare and Medicaid regulations state that only a Physician, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse, or discharge planner may sign the physician certification statement form.