



PHYSICIAN CERTIFICATION STATEMENT (PCS)

For Non-Emergency Ambulance Transportation

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Transport: \_\_\_\_\_

Transport Origin: \_\_\_\_\_ Floor/Unit: \_\_\_\_\_

Transport Destination: \_\_\_\_\_

Round Trip? [ ] Yes [ ] No

Complete form by explaining reason(s) why patient requires non-emergency ambulance services. Note: A "bed confined" patient is one who cannot get up from bed without assistance, cannot ambulate, and cannot sit in a chair (including a wheelchair).

Patient is unable to sit or travel in a wheelchair due to:

[ ] ALS (Advanced Life Support Certified EMT) monitoring/treatment is required during transport. (Please check off and explain in detail any of the following diagnosis listed below that would support the ambulance.)

- [ ] Ventilator dependent [ ] IV medications required en route [ ] ECG monitoring is required en route [ ] There are situations that do not fit above: (Please explain below)

[ ] BLS (Basic Life Support Certified EMT) monitoring/treatment is required during transport. (Please check off and explain in detail any of the following diagnosis listed below that would support the ambulance.)

- [ ] Requires assistance to administer oxygen en route: (Please explain below) [ ] Requires suctioning/airway control en route [ ] Psychiatric [ ] Requires restraints [ ] Flight Risk (Please explain below) [ ] Risk of falling out of a wheelchair in motion due to: (Please explain below) [ ] Isolation Precautions due to: (Please explain below) [ ] Orthopedic Device that prevents transport by wheelchair or other means: (Please explain below)

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

Print Physician's Name

Physician's Signature

Date

A PA, NP, CNS, RN, or a Discharge Planner employed by the hospital or facility where the patient is treated and has knowledge of the patient's condition at the time the transport was ordered may sign the form. Please circle one:

- RN Discharge Planner NP PA CNS

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.