Communication Center 817-927-9620 fax 817-927-9671 • **Business Office** 817-923-3700

Physicians Certification Statement for Ambulance Services (PCS)

Part 1: General Information

Patient's Name

Date of Transport:

Part 2: Why is the Ambulance Necessary?

Non-emergency Transport – This patient is:

- ☐ **Bedconfined**, i.e. Unable to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair
- ☐ Able to tolerate a wheelchair but is **medically unstable** due to other conditions indicated in the narrative below
- ☐ **Decreased level of consciousness**
- ☐ Requires **oxygen** due to ________________________________
- ☐ Requires airway **monitoring** or **suctioning**
- ☐ Requires cardiac **EKG** monitoring or **IV** maintenance
- ☐ **Comatose**
- ☐ Heavily **medicated**/chemically restrained
- ☐ **Bedconfined** due to **paralysis**
- ☐ Has a **psychiatric** condition which requires supervision
- ☐ Is **combative** danger to self or others and needs to be restrained
- ☐ Has **decubitus ulcers** & unable to sit during transportation
- ☐ Requires **isolation** precaution (VRE, MRSA, etc.)
- ☐ **Other Narrative:**

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Part 3: Physician Signature

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by Medicare or Medicaid to support the determination of medical necessity for ambulance services.
I am a representative of the institution named below, which has or will furnish care to the above named patient. By signing below, I acknowledge that the patient was transported from or received by the institution named below. My signature below may be used by MedStar as part of its documentation to submit a claim to Medicare for its services. By signing this form, neither I nor the institution named below will be held financially responsible for any care or other services provided. This signature is not an acceptance of financial responsibility for the patient.

**** We need physicians original sig for regularly transported dialysis patients.**

Physician's Printed Name: ____________________________________ NPI.: _______________

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Original Signature of Physician Date Signed

If not signed by physician:

Printed name of who signed:____

Title: (circle one) RN / NP / CNS / PA / Discharge Planner

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Facility Name