[Patient Sticker, *if available*]

Physician's Certification Statement for Ambulance Transportation (PCS)

The completed form should be faxed to MedStar Mobile Healthcare at: (817) 632-0537
Communications Center (817) 927-9620 - Business office (817) 923-3700

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ **(PCS is valid for round trips on this date and for all repetitive trips in the 60-day range.)**

Origin: _____ Destination: _____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

_____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO **Describe**:_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

2) Is this patient "bed confined" as defined ? ☐ Yes ☐ No - *To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without Assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair - Ref. 42 CFR 410.40(d)*

3) Can this patient safely be transported by car or wheelchair (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) In addition to completing questions 1-3 above, please check any of the following conditions that require transport by Ambulance:

☐ Contractures ☐ Non-healed Fracture ☐ Moderate/Severe pain on movement

☐ Danger to self or others ☐ IV Meds/fluids required

☐ Paralysis (Hemi, Semi, Quad)

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

☐ Requires continuous oxygen or airway monitoring. **Explain**: _____

☐ Patient is **(Circle)**: confused combative lethargic comatose

_____

☐ Cardiac/hemodynamic monitoring required enroute **Explain**: _____

☐ DVT requires elevation of lower extremity

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

☐ Unable to maintain erect sitting position in a chair for time needed to transport

☐ Unable to sit in a chair or wheelchair due to decubitus ulcers on buttocks; Grade **(Circle One)**: I II III IV V Ungradable

☐ Morbid obesity requires additional personnel/equipment to safely handle patient. Weight:_____lbs., Height: _____

☐ Special handling/isolation required. **Explain**: _____

SECTION III – SIGNATURE OF PHYSICIAN OR 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 and that other forms of transport are contraindicated. 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 I represent that I have personal knowledge of the patient's condition at the time of transport.

_____ _____

Signature of Physician* or Healthcare Professional **Date Signed**

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

***Form must be signed only by patient's attending physician for scheduled, repetitive transports.** *For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign **(please check appropriate box)**:*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner ☐ Licensed Vocational Nurse