Physician Certification Statement (PCS)

for Non-Emergency Ambulance Transportation Services

Initial Transport Date: ___ / ___ / ___

Repetitive Transport Expiration Date (Max 60 Days) ___ / ___ / ___

Patient's Name: ____

Medicare #: ___ ___ ___ ___ ___ ___ ___ ___ ___ (___)

Patient Picked Up At: ________________ Patient Transported To: ________________

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: 1) bed confined or 2) suffering from a condition such that transport by ambulance is medically required. To be "bed confined" the patient must be unable to get up from bed without assistance; AND unable to ambulate; AND unable to sit in a chair or wheelchair (Note: All three of these conditions must be met in order for the patient to qualify as bed confined).

ALL THREE SECTIONS MUST BE COMPLETED OR THIS PCS WILL BE CONSIDERED INVALID:

1) Is this patient "bed confined" as defined above? • Yes • No

2) What MEDICAL OR PHYSICAL CONDITION does this patient present ON THE DATE OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance:

____

____

3) Can this patient be safely transported strapped in a wheelchair bolted to the floor unattended in the back of a moving wheelchair van? • Yes • No

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, and that this patient requires ambulance transport. I understand that this information will be used by the Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS") to support the determination of medical necessity for ambulance services.

____ ________________

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

PRINT NAME: ______________________________

If signed by a Healthcare Professional, other than the attending physician,
please circle title of signer: •Physician's Assistant •Clinical Nurse Specialist •Registered Nurse •Nurse Practitioner •Discharge Planner

Fax to (419) 499-2216