

(AMBULANCE) PHYSICIAN CERTIFICATION STATEMENT FOR MEDICAL NECESSITY



Community Ambulance Service
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Additional blank PCS forms may be downloaded from the Community Ambulance website. PCS Forms may also be completed online and printed for use.
www.communityambulance.org

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

DATE OF SERVICE: _____ PATIENT NAME: _____

PATIENT TRANSPORTED FROM: _____ D.O.B. _____

PATIENT DESTINATION: _____

Hospital-to-Hospital Transfers: What service(s) were not available at the 1st facility?

Please check the appropriate medical condition(s) listed below which would necessitate transport by ambulance and make all other means of transport contraindicated based on patient safety and health. PLEASE CHECK ALL THAT APPLY.

- Bed Confined:** All three criteria below must be met to qualify for bed confinement.
 1. Unable to ambulate.
 2. Unable to get out of bed without assistance.
 3. Unable to safely sit up in a wheelchair:
 - Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning.
 - Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers. buttocks _____ coccyx _____ hip _____ other _____
- Morbid Obesity** requires additional personnel / equipment to handle. **Weight of Pt.** _____
- Suffers from **paralysis**: hemi _____ quad _____ para _____ **DVT** requires elevation of a lower extremity.
- Patient has **contractures**: upper _____ lower _____ both _____ **Seizure** prone and requires trained monitoring.
- Patient has non-healed **fractures**. Location of fx(s): _____
- Exhibiting signs of a **decreased level of consciousness**: confused _____ combative _____ lethargic _____ comatose _____
- Patient requires **Isolation Precautions**; reason _____
- IV** medications/fluids required during transport.
- Cardiac/** Hemodynamic monitoring required during transport. Specify: _____
- Orthopedic device** (backboard, halo, use of pins in traction, etc.) requiring special handling during transport.
- Patient requires **airway** monitoring or suctioning. Portable **ventilator** required.
- Trained personnel required for administering, and/ or regulating **oxygen** en route.
- Patient is a **danger to self or others** (requires monitoring). **Restraints** (physical or chemical) anticipated or used during transport.
- Patient requires **elopement precautions** (flight risk).

Please list any **Medical Hx / Dx**, which can help substantiate the above conditions: _____

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.

Print: Attending Physician's Name / Title *** (see below)	Signature: Attending Physician *** (see below)
	Date Signed: _____

***** For Scheduled Repetitive Patients (e.g., dialysis patients) this authorization must be completed and signed, prior to the first transport, by the attending physician**

*** For **unscheduled or scheduled non-repetitive transports** the Attending Physician, Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner, Registered Nurse Or Discharge Planner (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished may sign the authorization.