Personal Care Ambulance Transport

Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name: _____ DOB: _____ Level of Care: ☐ BLS ☐ ALS

Transport Date*: _____ Expiration Date (Max 60 Days From Date Signed): _____

* This PCS is valid for all trips on the date of transport (i.e. round trips) and for scheduled/repetitive trips in the 60-day range as noted above.

Origin: _____ Destination: _____

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. To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; **AND** (2) *unable* to ambulate; **AND** (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered by the medical professional signing below for this form to be valid:

1. Describe the PHYSICAL or MENTAL condition of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:
   _____
   _____
2. Is this patient "Bed Confined" as defined above? ☐ Yes ☐ No
3. Can this patient be transported by car or wheelchair van (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 apply*:
   *Note: supporting documentation for any boxes checked must be maintained in the patient's medical records

☐ Contractures ☐ Non-healed fractures ☐ Moderate / severe pain on movement
☐ Danger to self / others ☐ IV meds / fluids required ☐ Special handling / isolation required
☐ Patient is confused, combative, lethargic, or comatose ☐ DVT requires elevation of a lower extremity
☐ Third party assistance / attendant required to apply, administer or regulate or adjust oxygen enroute
☐ Restraints (physical or chemical) anticipated or used during transport
☐ Orthopedic device (backboard, halo, use of pins in traction, ect) 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 or other wounds
☐ Morbid obesity requires additional personnel / equipment to safely handle patient
☐ Other (specify)_____

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 due to the reasons documented on this form. 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 Print Name and Title (MD, RN, etc.)

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

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