Physician Certification Statement for Medical Necessity

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.

Please print clearly and have physician sign where indicated below. Complete ALL sections of this form.

Section 1 - Beneficiary Information

Name: Last Name **First Name** **Middle Initial**

Diagnosis

DOB:	**Sex:**	**SSN:**
Date of Transport:	☐ If multiple transports required (Dialysis, Radiation, etc.)? Check here to validate this PCS for Maximum of 60 Days.	_____ Initial
Run Number:		

Section 2 - Transportation Information

Transport From:	**Unit/Bed**	**Discharge?** ___ Yes ___ No
Transport To:	**Unit/Bed**	**Discharge?** ___ Yes ___ No

Section 3 - Medical Necessity

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 quality 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.

a. Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning.

b. 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.

☐ Suffers from **paralysis**: ___ hemi ___ quad ___ para

☐ Patient has contractures: ___ upper ___ lower ___ both

☐ Patient has non-healed fractures. Location: _____

☐ Exhibiting signs of a **decreased level of consciousness**: ___ confused ___ combative ___ lethargic ___ comato

☐ **DVT** requires elevation of a lower extremity.

☐ **Seizure** prone and requires trained monitoring.

☐ 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: _____

Other Conditions not listed above:

Section 4 - Ordering Physician Information and Signature

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patie nt requires transport by ambulance and should not be transported by any other means. 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 that I have personal knowledge of the patient's condition at the time of transport.

Print Name of Physician or HealthCare Professional:	
Signature of Physician or HealthCare Professional:	

CREDENTIALS:

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

From transports done by APEX PARAMEDICS, you may fax to (720) 389-6640