

Place Label here:

NON-REPETITIVE PHYSICIAN CERTIFICATION STATEMENT (PCS)

EMERGENT/ NON EMERGENT TRANSPORT
ALS TRANSPORT ___ BLS TRANSPORT ___
(check one)

SECTION I – GENERAL INFORMATION

- 1) Patient's Name: _____ Date of Birth: _____
- 2) Transport From: _____ Transport To: _____
- 3) Transport Date: _____
- 4) Attending Physician: _____ **Required Physician NPI #** _____
- 5) Medicaid ID # _____ Medicare ID # _____

SECTION II - MEDICAL NECESSITY

- 1) **Medical Condition/Diagnosis That Requires Ambulance THIS Transport** _____

- 2) **Bed Confined?** YES or NO **Bed Confined Definition - must meet all criteria: Inability to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair, per CMS rules.**
(Circle One)
- 3) **Please Check All Required That Apply:**

<input type="checkbox"/> Airway Compromise-Suction	<input type="checkbox"/> Cardiac Monitoring	<input type="checkbox"/> Comatose
<input type="checkbox"/> Confusion	<input type="checkbox"/> Contractures	<input type="checkbox"/> Danger to self/others
<input type="checkbox"/> Isolation Precautions	<input type="checkbox"/> IV Maintenance	<input type="checkbox"/> Moderate/severe pain on movement
<input type="checkbox"/> Paralysis (hemi, semi, quad)	<input type="checkbox"/> Non-healed fractures	<input type="checkbox"/> Oxygen monitored by trained staff
<input type="checkbox"/> Should not stand/pivot/ambulate	<input type="checkbox"/> Restraints	<input type="checkbox"/> Oxygen self-monitored
<input type="checkbox"/> Morbid Obesity: Weight _____ LBS	<input type="checkbox"/> Vent Dependent	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Unable to sit in a wheelchair due to decubitus ulcers or other wounds	<input type="checkbox"/> Monitored by trained staff for _____	
<input type="checkbox"/> Unable to tolerate a seated position during transport		
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Medical Attendant Required	
- 4) What services are required at receiving facility that **CAN NOT** be provided at the sending facility?

- 5) Closest facility? YES or NO If NO, why is transport to more distant facility required?
(Circle One)

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transport by medically trained personnel is required. I certify that the above information will be used by the Centers of Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services.

Print Name: _____ **Credential: ___Physician**
Signature : _____ Date Signed: _____

Who Can Sign Only
Physician