Physician Certification Statement (PCS) for Non-Emergency Ambulance Services

MedStar Transport Coordinator Communications Center (817)-927-9620, FAX (817) 632-0537

SECTION I – GENERAL INFORMATION

Patient's Name:_____Date of Birth:_____Medicare #: _____

Transport Date:_____(Valid for round trips this date, or for scheduled repetitive trips for 60 days from date signed below.)

Origin:_____ Destination:_____

Is the Patient's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is the patient being transported to another facility? _____

_____

If hospital to hospital transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice Pt, is this transport related to Pt's terminal illness? ☐ YES ☐ NO Describe:_____

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. **The patient must be either "bed confined" or suffer from a condition that makes other forms of transportation (such as a wheelchair van) inappropriate.** The healthcare professional signing below must certify the following:

1) The transport is necessary for the following treatment or evaluation: _____

2) ☐ Yes ☐ No The patient is "bed confined" (all three of the following must apply: The patient is:
1. *unable* to get up from bed without assistance; AND 2. *unable* to ambulate; AND 3. *unable* to sit in a chair.

3) ☐ Yes ☐ No The patient cannot be safely be transported by car or wheelchair van (e.g., cannot safely sit during transport, or requires an attendant or monitoring)

*****If you cannot answer "Yes" to either question 2 or 3 above, the transport likely does not meet the requirements for medical necessity. Please contact MedStar** at (817)-927-9620

4) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patient's condition:

_____

_____

_____

5) ***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 ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement

☐ Danger to self/others ☐ IV meds/fluids required ☐ Patient is combative ☐ Need, or possible need, for restraints

☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self-administer

☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport

☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED 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 and that other forms of transport are contraindicated. 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 Authorized Healthcare Professional Date Signed

(For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)

* _____

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

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Licensed Practical Nurse ☐ Case Manager

☐ Nurse Practitioner ☐ Registered Nurse ☐ Social Worker ☐ Discharge Planner