Phone : 765-396-9483 Intake Fax: 765-396-4429 Billing Fax: 765-396-4427

Physician Certification Statement for Non-Emergency Ambulance Services

SECTION I – GENERAL INFORMATION

Patient's Name: _____ (Place sticker here)

Date of Birth: _____ SSN:_____

Medicare #: _____ Medicaid #:_____

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

Additional Insurance_____ Policy #_____ Group #_____

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

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

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"? ☐ Yes ☐ No
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.)

3) Can this patient safely be transported by car or wheelchair van 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:

☐ 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

☐ Cardiac/hemodynamic monitoring required enroute

☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport

☐ Unable to maintain upright 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 on buttocks

☐ 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 CREDENTIALS (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