

PHYSICIAN CERTIFICATION STATEMENT (PCS)

Recent changes in the Federal Regulations for Ambulance Coverage require a physician certification statement to be completed for non-emergency ambulance transports (42 CFR 410.40(d)) in order for the ambulance provider to bill third party payers.

NAME OF PATIENT: _____

DATE OF SERVICE _____

POINT OF PICK-UP _____

POINT OF DELIVERY _____

(If transfer is between hospitals, what services are not available at originating facility: _____)

The Patient can only be transported safely by ambulance. Wheelchair van or other transportation would not be safe for this patient due to the following medical condition(s):

- Bed confined, i.e., unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair.
- needs IV to be maintained.
- could only be moved by stretcher because of _____
- requires airway monitoring or suctioning.
- requires oxygen during transport because of _____
- requires cardiac EKG monitoring.
- seizure prone and requires trained monitoring.
- medicated and requires trained monitoring.
- unable to sit due to sacral decubitus ulcers
- combative and needs to be restrained.
- unconscious or in shock
- unable to sit or hold self in place, even with seatbelts, due to paralysis of the _____
- need to remain immobile due to fracture or a suspected fracture.
- contractures of the _____
- must be transported by ambulance to higher level of care due to _____
- additional special services required (describe) _____

CERTIFICATION BY PHYSICIAN: *I certify that transportation by ambulance for the above patient is medically necessary.*

Printed Name of Physician

 X _____ DATE _____
Signature of Physician

OR

Name of R.N., P.A., C.N.S., N.P., or Discharger Planner

 X _____ DATE _____
Signature