Place patient sticker here.

Please call 1-877-364-8711 if you have any questions regarding this form.

PHYSICIAN CERTIFICATION STATEMENT (PCS)

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.

***Indicates required field**

***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):

***CHECK ALL THAT APPLY**

- ☐ Bed confined; unable to get up from bed without assistance, unable to ambulate; unable to sit in a wheelchair because of ______________________
- ☐ Requires (circle all that apply); AIRWAY MONITORING/SUCTIONING, IV MONITORING/MAINTENANCE, EKG MONITORING
- ☐ Could only be moved by stretcher because of ______________________
- ☐ Requires oxygen during transport because of ______________________
- ☐ Seizure prone and requires trained monitoring.
- ☐ Medicated and requires trained monitoring.
- ☐ Unable to sit due to decubitus ulcers of the ______________________
- ☐ Requires (circle all that apply); PSYCHIATRIC HOLD, REQUIRES RESTRAINTS, FLIGHT RISK
- ☐ 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) ______________________

***PLEASE CHECK YOUR CREDENTIALS BELOW AND PRINT AND SIGN YOUR NAME:**

I certify that transportation by ambulance for the above patient is medically necessary. I certify our institution has furnished care or other services to the above named patient. In the event that you are unable to obtain the signature of the patient or another authorized representative, I hereby sign pursuant to 42 C.F.R. 424.36(b)(4).

☐ ***PHYSICIAN*** ☐ ***RN*** ☐ ***N.P.*** ☐ ***P.A.*** ☐ ***DISCHARGE PLANNER*** ☐ ***C.N.S.***

______________________ X ______________________ DATE ____________

*** Printed Name** ***Signature**