

AMERICARE AMBULANCE
PHYSICIAN CERTIFICATION STATEMENT (PCS)
FOR NON-EMERGENCY AMBULANCE TRANSPORT

Please print clearly and have Physician or Medical Support Staff sign where indicated below. Complete ALL sections of this form.
See reverse for important information on completing this form.

SECTION 1 - Beneficiary Information

Patient's Name: Date of Birth:
SS#: Diagnosis:
Transportation Date:
If multiple transports required (dialysis, radiation, etc)
Check here to validate this PCS for Maximum of 60 days
initials

SECTION 2 - Transportation Information

Transport From: Transport To:
If hospital to hospital transfer, check appropriate box below indicating the reason for transfer:
For the care of specialist / specialized equipment / higher level of care
For the benefit of a preferred physician
For the nearness of the family members
Other (specify)

SECTION 3 - Medical Necessity Information- See Reverse for Definition of Medical Necessity

NOTE: LACK OF ALTERNATIVE TRANSPORTATION SERVICES DOES NOT CREATE A MEDICAL NECESSITY FOR AMBULANCE SERVICES.

Describe patient's condition (not diagnosis) at the time of pickup and /or discharge that necessitated utilization of an ambulance. (see reverse for CMS definition of medical necessity)

Is the patient BED CONFINED as defined by CMS regulations? (see reverse for definition) YES NO

Please check any of the following that apply:

- Contractures
Non-healed fractures
Acute or Chronic confusion
Comatose
Moderate/sever pain on movement
Danger to self or others
Hemiparesis/Hemiplegia
Limited R.O.M of lower extremities
Non-weight bearing
Pregnancy complications
S.O.B/Dyspnea
Combative / needs restraints
DVT requires elevation of lower extremity
Requires oxygen-unable to self administer
Special handling / isolation / infection control precautions required
Weakness/lethargic
Other (specify)
Unable to tolerate seated position for time needed to transport
Unable to sit in chair or wheelchair due to decubitus ulcer or other
Morbid obesity requires additional personnel/equipment
Orthopedic device requiring special handling during transport
Seizure prone / requires monitoring
Requires airway monitoring or suctioning
Ventilation dependent
IV Medications/fluids required during transport
Severe muscular weakness and de-conditioned state precludes any significant physical activity
Patient safety, Risk of falling off W/C or stretcher while in motion (not related to obesity)
Hemodynamic / cardiac monitoring required
Paraplegia / quadriplegia

SECTION 4 - Physician / Medical Support Staff

I certify that the above information is true and correct based on my evaluation of this patient. 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 service.

Signature of ordering/attending Physician or Medical Support Staff Date Signed

Printed name of Physician or Medical Support Staff
Nurse
Physician
Physicians Assistant
Clinical Nurse Specialist
Registered Nurse
Nurse Practitioner
Discharge Planner