

Section 1 - Beneficiary Information

Patient Name: _____ Date of Transport: ____/____/____

Transported From: _____ Transported To: _____

Physician's Certification Statement (PCS) For Non-Emergency Ambulance Transport

Unit: _____ CS # _____

Section 2 - Medical Necessity Information for Non-Emergency Transportation

A. Can the patient be safely transported by car, taxi, bus, or a wheelchair van? Yes No

If yes, the patient does not meet the criteria for ambulance transportation.

B. Please describe the reasons why the patient requires monitoring and/or transport by ambulance _____

C. Is the beneficiary able to get up from bed without assistance? Yes No

D. Is the beneficiary able to ambulate? Yes No

E. Is the beneficiary able to sit in a chair or wheelchair? Yes No

If the answer is "no" for C, D, or E, please describe why: _____

Section 3 - For Inter-facility Transfer

A. Is the patient being transferred to a higher level of care? Yes No

B. Please list/describe facilities of procedures required/available at destination facility not available at the originating facility? _____

C. Is the patient discharged from the originating facility? Yes No Is patient an: Inpatient Outpatient

D. Is the beneficiary able to ambulate? Yes No

If no, describe why the patient has to be transported to the further facility. _____

Section 4 - Additional Reasons for Ambulance Transport - Complete all that are applicable to this patient

- A. Is the patient (check all that apply)
 - Critically Injured Critical Illness Unstable
 - In Need of Immediate Attention
- B. Needs immobilization due to recent fracture or potential fracture:
 - Hip Leg Spine
 - Other: _____
- C. Contractures: Upper Ext Lower Ext Fetal
Paralysis: Para Quad Hemi
- D. Decubitus Ulcers: Size: _____ Stage: _____
 Buttocks Coccyx Hip
Other: _____
- E. Severe Pain - Pain Scale (1-10): _____
Explain: _____
- F. Requires isolation precautions (VRE, MRSA, etc.)? Yes No
If yes, why? _____
- G. Mental Status... Is this condition:
 - New Onset Normal Status Status Change
 - Does the patient exhibit: Hostility Violent/Combative
 - Agitation Delirium Non Compliant
 - Is the altered mental status the result of sedation? Yes No
 - Type: _____

- H. Patient's level of consciousness precludes other means of transport? Yes No If yes, why? _____
- I. Decreased level of consciousness:
 - Unconscious Syncope Unresponsive Incoherent
 - Lethargic Semi-conscious, stuporous Seizure-prone
 - Intermittent consciousness Hallucinating
- J. Restraints required: Type: _____
Reason for restraint To prevent injury to self or others
 Flight risk To maintain upright position safely
- K. Patient is too weak to travel by other means? Yes No If yes, why? _____
- L. Requires continuous oxygen & monitoring by trained staff? Yes No If yes, why? _____
- M. Requires airway monitoring or suctioning? Yes No
- N. Patient is ventilator dependent? Yes No
- O. Patient requires continuous IV therapy? Yes No
- P. Patient requires cardiac monitoring? Yes No
- Q. Patient is hemodynamically unstable? Yes No
Explain: _____

Other medical conditions that support the medical necessity of ambulance transportation: _____

Section 5 - 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 (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

If this box is checked, I also certify that the patient is physically and mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated with has furnished care, services, or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37. The specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows: _____

Signature of Physician* or Healthcare Professional _____

Date Signed _____

Printed Name & Title (Please print legibly)

* 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
- Licensed Practical Nurse
- Registered Nurse
- Nurse Practitioner
- Discharge Planner