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.***

_____ X_____ DATE_____

Printed Name of Physician — Signature of Physician

OR

_____ X_____ DATE_____

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