Physician Certification Statement (PCS)

Non-Emergency Ambulance Transportation

American Ambulance Service, Inc.
One American Way Norwich, CT 06360
Office: (860) 886-1463 Fax: (860) 885-2978

Patient Name: **Initial Date of Certification:**

Patient's SSN: **Run #:**

Patient DOB:

Medicare No: **Other Insurance:** _____

Medicaid No:

Mail To:

Medicare guidelines state, ambulance transportation would be covered when the patient's condition is such that use of any other method of transportation is contraindicated. If other modes of transportation could have been used without dangering the patient's health, then benefits cannot be paid for ambulance services. A PCS, in and of itself, does not establish medical necessity nor does it guarantee payment for Medicare coverage of ambulance transportation.

MEDICAL NECESSITY QUESTIONNAIRE:

To be "bed confined" the patient must be: (1) unable to get up from bed without assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered for this form to be valid:

1) Is this patient "bed confined" as described above? Yes___ (if checked, complete #2 & #3 below) No___

2) Describe the PHYSICAL OR MENTAL CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

3) Please check any of the following conditions that apply*:

**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records.*

___ Advanced Dementia, late stage Alzheimer's, severe Altered Mental Status, decreased level of consciousness.
___ Extreme muscle atrophy, risk of falling out of wheelchair for time needed to transport.
___ Requires airway monitoring and suctioning during transport.
___ Cardiac/Hemodynamic monitoring during transport.
___ IV infusion required during transport.
___ Patient is confused, lethargic, or comatose and requires trained personnel to monitor condition during transport.
___ Seizure prone and requires trained personnel to monitor condition during transport.
___ Medicated and needs trained personnel to monitor condition during transport.
___ Danger to self and/or others, restraints anticipated or used during transport. Verbal __, Chemical __, Physical __, Flight risk ___
___ Moderate/severe pain on movement Site: _____
___ Suffers from paralysis or contractures. Upper Extremities ___ Lower Extremities ___, Fetal ___
___ Has decubitus ulcers (Stage_____ Size_____) and requires wound precautions. Buttocks ___, Sacral ___, Back ___, Hip ___
___ Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute. Liters per minute (LPM):____
___ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport.
___ Morbid obesity requires additional personnel/equipment to safely handle patient.

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 Services (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 or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated 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). I***n 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 **Printed Name** Date Signed

__ Physician Assistant __ Clinical Nurse Specialist __ Registered Nurse __ Nurse Practitioner __ Discharge Planner __ MD/DO

**** Form must be signed only by patient's attending physician for scheduled, repetitive transports.***