

# Mobile Medical Response

## PHYSICIAN CERTIFICATION STATEMENT (PCS)

Please Fax Completed Form to (989) 752-6803. To Schedule a Transport or for Assistance

Please Call (989) 907-2020 or (866) 781-3218

### SECTION I – GENERAL INFORMATION

- 1) Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
- 2) Transport From: \_\_\_\_\_ Transport To: \_\_\_\_\_
- 3) Transport Date: \_\_\_\_\_
- 4) **Closest Appropriate Facility?** YES or NO If NO, why is transport to more distance facility required?  
\_\_\_\_\_
- 5) Attending Physician: \_\_\_\_\_

### SECTION II - MEDICAL NECESSITY

1) **Medical Condition/Diagnosis That Requires Ambulance Transport** \_\_\_\_\_

2) **Bed Confined?** YES or NO (Circle One) CSM Definition: *Inability to get up from bed without assistance, ambulate or sit in a chair, including a wheelchair (must meet all criteria).*

3) **Please Check All Required That Apply:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Airway Compromise-Suction   | <input type="checkbox"/> Cardiac Monitoring                                  | <input type="checkbox"/> Comatose                             |
| <input type="checkbox"/> Confusion   | <input type="checkbox"/> Contractures  | <input type="checkbox"/> Danger to Self/Others                |
| <input type="checkbox"/> Isolation Precautions   | <input type="checkbox"/> IV Maintenance                                      | <input type="checkbox"/> Moderate Severe Pain On Movement     |
| <input type="checkbox"/> Morbid Obesity  | <input type="checkbox"/> Non-healed Fractures                                | <input type="checkbox"/> Oxygen & Monitoring by Trained Staff |
| <input type="checkbox"/> Paralysis (hemi, semi, quad)  | <input type="checkbox"/> Psychiatric Care                                    | <input type="checkbox"/> Restraints                           |
| <input type="checkbox"/> Should not- Stand/Pivot/Ambulate                                      | <input type="checkbox"/> Unable to Tolerate Seated Position During Transport |   |
| <input type="checkbox"/> Unable to sit in a Wheelchair due to decubitus ulcers or Other Wounds | <input type="checkbox"/> Vent Dependent                                      |   |
| <input type="checkbox"/> Other (Specify) _____   |  |   |

### SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

*In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transport by medically trained personnel is required. I certify that the above information will be used by the Centers of Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services.*

Print Name: \_\_\_\_\_ (Credential) \_\_\_\_\_

Sign Name: \_\_\_\_\_ Date Signed \_\_\_\_\_

Who Can Sign a PCS:

For BCBS Patients: **Physician, Physician Assistant, Registered Nurse, Discharge Planner, or Nurse Practitioner**

For Medicare & Medicaid: **Physician, Physician Assistant, Registered Nurse, Discharge Planner, or Nurse Practitioner**