Mobile Medical Response

PHYSICIAN CERTIFICATION STATEMENT (PCS) FOR REPETITIVE TRANSPORTS

To Schedule a Transport or for Assistance Please Call (989) 907-2020 or (866) 781-3218.

Please Fax Completed Form to (989) 752-6803. *Please mail the Original PCS to Mobile Medical Response 834 S. Washington Ave Saginaw MI 48605

SECTION I – GENERAL INFORMATION

1) Patient's Name: _____ Date of Birth: _____

2) Transport From: _____ Transport To: _____

3) Transport Date: _____ Patient's Medicaid ID Number: _____

4) Type of transport and Frequency (**Medicaid only**) _____

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, sit in a chair, and including a wheelchair (must meet all three criteria).*

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

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

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 Physician Name: _____ **(Credential)** _____

Signed Physician Name: _____ **Date Signed** _____

Physician NPI Number: _____

Who Can Sign a PCS: **Only a physician can sign the PCS for repetitive transports**

A PCS for a Medicaid recipient will cover one month of treatment of a repetitive patient