

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) Attending Physician: _____

SECTION II - MEDICAL NECESSITY

- 1) **Medical Condition/Diagnosis That Requires Ambulance Transport** _____

- 2) **Bed Confined?** **YES** or **NO** CMS Definition: *Inability to get up from bed without assistance, ambulate or sit in a chair, including a wheelchair (must meet all criteria).*
(Circle One)
- 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"/> Paralysis (hemi, semi, quad) | <input type="checkbox"/> Non-healed fractures | <input type="checkbox"/> Oxygen & monitoring by trained staff |
| <input type="checkbox"/> Should not stand/pivot/ambulate | <input type="checkbox"/> Restraints | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Unable to sit in a wheelchair due to decubitus ulcers or other wounds | <input type="checkbox"/> Vent dependent | |
| <input type="checkbox"/> Unable to tolerate a seated position during transport | <input type="checkbox"/> Morbid Obesity | |
| <input type="checkbox"/> Other (specify) _____ | | |
- 4) What services are required at receiving facility that **CAN NOT** be provided at the sending facility?

- 5) Closest facility? **YES** or **NO** If **NO**, why is transport to more distant facility required?
(Circle One)

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*