



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 **Bed Confined Definition:** *Inability to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair, per CMS rules.*
(Circle One) **(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"/> 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"/> Morbid Obesity | <input type="checkbox"/> Vent Dependent | |
| <input type="checkbox"/> Unable to sit in a wheelchair due to decubitus ulcers or other wounds | | |
| <input type="checkbox"/> Unable to tolerate a seated position during transport | | |
| <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: Physician, Physician Assistant, Registered Nurse, Nurse Practitioner or Discharge Planner