NON-REPETITIVE 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 THIS Transport __________________________

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

3) Please Check All Required That Apply:
   __ Airway Compromise-Suction
   __ Confusion
   __ Isolation Precautions
   __ Paralysis (hemi, semi, quad)
   __ Should not stand/pivot/ambulate
   __ Morbid Obesity: Weight _____ LBS
   __ Unable to sit in a wheelchair due to decubitus ulcers or other wounds
   __ Unable to tolerate a seated position during transport
   __ 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: ___Physician ___PA-C ___RN ___ NP ___DP

Sign Name: __________________________ Date Signed: __________________________

Physician NPI Number: __________________________ (as applicable)

Who Can Sign a Non-Repetitive PCS:
Physician, Physician Assistant, Registered Nurse, Nurse Practitioner or Discharge Planner

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