PHYSICIAN CERTIFICATION STATEMENT (PCS) REPETITIVE

Please *FAX* completed form to (989) 752-6803
***MAIL* the original form to:**
Mobile Medical Response
4305 State Street
Saginaw, MI 48603

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: ___________________________ Patient's Medicaid ID Number: ______________________
(If applicable)

4) Type of transport and frequency: ____

5) Attending Physician: ____

SECTION II - MEDICAL NECESSITY

1) ***Medical Condition/Diagnosis That Requires Ambulance 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
__ Unable to sit in a wheelchair due to decubitus ulcers or other wounds
__ Unable to tolerate a seated position during transport
__ Other (specify) ____

__Cardiac Monitoring
__ Contractures
__ IV Maintenance
__ Non-healed fractures
__ Restraints
__ Vent dependent

__ Comatose
__ Danger to self/others
__Moderate/severe pain on movement
__ Oxygen monitored by trained staff
__ Oxygen self-monitored
__ Psychiatric care
__ Monitored by trained staff for_________________________.

4) What services are required at receiving facility that **CAN NOT** be provided at the sending facility?
____

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

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.

Physician Name: ________________________________

Credential: MD / DO (circle)

Sign Name: ____________________________________

Date Signed ________________________

Physician NPI Number:___________________________

Who can sign REPETITIVE PCS Form: Only a **PHYSICIAN** can sign for REPETITIVE patients.

A REPETITIVE PCS for **Medicaid** patients is only valid for **30 days**,
all others are valid for 60 days.

DEC2018