REPETITIVE PATIENT

(AMBULANCE) PHYSICIAN CERTIFICATION STATEMENT FOR MEDICAL NECESSITY

DMCare Express
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A Physician Certification Statement (PCS) is required, pursuant to 42 C.F.R. 410.40(d) (2) and (3), by the Centers for Medicare and Medicaid (CMS) on all scheduled and unscheduled non-emergency transports. (Please see below for signature requirements)

***Sections 1 - 3 MUST be completed in order for the form to be compliant with state and federal billing regulations.**

Section 1

PATIENT NAME:	DOB:	MEDICARE/MEDICAID ID:
TRANSPORTED FROM:	TRANSPORTED TO:	ROUND TRIP? ☑ YES ☐ NO
DATE(s) OF SERVICE:	ORDERING PHYSICIAN'S PRINTED NAME:	ORDERING PHYSICIAN'S NPI:

Section 2

PLEASE PROVIDE DOCUMENTATION OF THE PATIENT'S MEDICAL CONDITION AT THE TIME OF TRANSPORT TO SUBSTANTIATE AMBULANCE MEDICAL NECESSITY.

All three criteria below must be met to qualify for **"bed confinement"**.

1. Unable to ambulate. ☑ YES ☐ NO
2. Unable to get out of bed without assistance. ☐ YES ☐ NO
3. Unable to safely sit up in a wheelchair: ☐ YES ☐ NO *if YES, complete 3-A. & 3-B.

☐ a. Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning.

☐ b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers. buttocks ____ coccyx ____ hip ____ other ____

****Under Medicare/Medicaid regulations, diagnosis of bed confinement by itself does not substantiate medical necessity**

Please list any **Medical Hx / Dx**, which substantiates transportation by ambulance, is medically required: _____

Section 3

FOR REPETITIVE PATIENTS (E.G., DIALYSIS PATIENTS) THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY A PHYSICIAN AS SET FORTH IN 42 C.F.R. §410.40(D)(2). FAILURE TO RETURN THE REQUIRED DOCUMENTATION MAY RESULT IN AN INTERRUPTION OF SERVICE AND MAY CAUSE A FINANCIAL BURDEN TO THE PATIENT

Physician Certification / Authorization: I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.

Physician's Printed Name & Licensure:	
Physician Signature:	Date Signed:

The Physician Certification Statement is valid for 60 days from the date of the physician's signature.

Additional blank PCS forms may be downloaded from the DMCare Express website. PCS forms may also be completed online and printed for use @ *www.dmcareexpress.org*