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## AMBULANCE TRANSPORTATION PHYSICIAN CERTIFICATION STATEMENT FOR MEDICAL NECESSITY

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? <input type="checkbox"/> YES <input type="checkbox"/> NO
	DATE(S) OF SERVICE:	ORDERING PHYSICIAN'S PRINTED NAME:			ORDERING PHYSICIAN'S NPI:

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

Section 2	<p style="color: red; font-size: small;">All three criteria below must be met to qualify for "bed confinement".</p> <p>1. Unable to ambulate. <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>2. Unable to get out of bed without assistance. <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span></p> <p>3. Unable to safely sit up in a wheelchair: <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO *if YES, complete 3-A. &amp; 3-B.</span></p> <p style="margin-left: 40px;"><input type="checkbox"/> 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.</p> <p style="margin-left: 40px;"><input type="checkbox"/> b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers.          buttocks _____ coccyx _____ hip _____ other _____</p> <p><b>**Under Medicare/Medicaid regulations, diagnosis of bed confinement by itself does not substantiate medical necessity</b></p>	
	<p>Please list any <b>Medical Hx / Dx</b>, which substantiates transportation by ambulance, is medically required: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

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.

Section 3	Authorized Healthcare Provider Completing The Form On Behalf Of The Ordering Physician:			
	<b>Title:</b>	<input type="checkbox"/> Attending Physician	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Clinical Nurse Specialist
		<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Discharge Planner
<b>Authorized Signature:</b>		<b>Date Signed:</b>		

Medicare and Medicaid regulations state that only a Physician, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse, or discharge planner may sign the physician certification statement form.