



# Physician's Certification Statement

(PCS)

FOR NON-EMERGENCY SCHEDULED AND UNSCHEDULED AMBULANCE TRANSPORTATION



PCS must be obtained within 48 hours after completion of the transport for unscheduled, non-emergency transport. The PCS is effective for 60 days for repetitive transports if there is no change in the patient's condition.

Transport Date		Certificate Expiration Date: (Max. 60 days)	
Patient Name (Last, First, MI)		Patient Medicare Number: Part B: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: ____/____/____	Age:	Patient's Social Security Number:
Transported From:		Transported to:	
Physician Printed Name:		Physician UPIN Number:	

### OPTION 1 AMBULANCE TRANSPORTATION NOT NECESSARY

In my professional opinion, this patient does not require transport by ambulance and can be safely transported by other means. The patient's condition is such that transportation by ambulance is not required because the means listed below are safe and acceptable:

- Patient can safely support him/herself while in a wheelchair and does not require monitoring by trained personnel.
- Patient is able to tolerate transportation by automobile or wheelchair van.

### OPTION 2 AMBULANCE TRANSPORTATION NECESSARY

In my professional medical opinion, this patient requires transportation by ambulance should not be transported by any other means. The patient's condition is such that the use of any other method of transport would be contraindicated.

The CMS definition of Bed Confinement is: the inability to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair at the Time of Service. (ALL MUST BE MET)

**Is your patient bed-confined as defined by Medicare (CMS) Regulation?** \_\_\_\_ YES \_\_\_\_ NO

If the patient does not meet the criteria for bed-confined, can the patient be safely transported by wheelchair van? \_\_\_\_ YES \_\_\_\_ NO

If NO, please check the appropriate medical condition(s) listed below which would necessitate transport by ambulance and make all other means of transportation contraindicated based on patient safety and health.

This patient: **\*\* (A) – MUST BE DEFINED IN OTHER\*\***

- |                                                                                                                                                                                                                                    |                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Requires continuous oxygen monitoring by trained staff.<br><i>NOTE: Patients who are generally mobile with portable oxygen would not require ambulance transport based solely on the need for oxygen.</i> | <input type="checkbox"/> Has to remain immobile because of a fracture/possibility of fracture which has not been set. |
| <input type="checkbox"/> Requires airway monitoring and/or suctioning.                                                                                                                                                             | <input type="checkbox"/> Is ventilator dependent.                                                                     |
| <input type="checkbox"/> Requires restraints or sedation.                                                                                                                                                                          | <input type="checkbox"/> Has contractures. (A)                                                                        |
| <input type="checkbox"/> Is comatose and requires trained monitoring.                                                                                                                                                              | <input type="checkbox"/> Has decubitus ulcers & requires wound precautions. (A)                                       |
| <input type="checkbox"/> Is on hip precautions and cannot sit safely. (A)                                                                                                                                                          | <input type="checkbox"/> Requires cardiac monitoring                                                                  |
|                                                                                                                                                                                                                                    | <input type="checkbox"/> Is exhibiting signs of a decreased level of consciousness. (A)                               |

OTHER\*\* pertinent information relating to medical necessity of ambulance transport: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### OPTION 3 FOR HOSPITAL TO HOSPITAL TRANSFERS ONLY

Is the patient being transferred to a higher level of care?  YES  NO

**If YES, the following items must be completed:**

(A) Please list/describe facilities or procedures required/available at the destination facility NOT available at the originating facility: \_\_\_\_\_

(B) Was the patient discharged from originating facility either as an inpatient, or outpatient?  YES  NO

(C) Was the patient transported to the closest appropriate facility?  YES  NO

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the above information represents an accurate assessment of the patient's medical condition(s) and that in my professional opinion, this patient requires transport by ambulance and should not be transported by any other means. I understand that this will be used by CMS to support the determination of medical necessity for non-emergency ambulance services.

To be completed prior to the transport and given to Tri-State Ambulance, Inc. personnel or faxed to 608-775-1518 within 48 hours of transport

221 Buchner Place, La Crosse, WI 54603 Phone: 608-775-1515 Fax: 608-775-1518

[www.tristateambulance.org](http://www.tristateambulance.org)

**Medical Care in Motion**