Physician Certification Statement of Medical Necessity for Ambulance Transportation

SECTION I – GENERAL INFORMATION			
Last Name:	First Name:	Middle Initial:	Date of Service:
Sex: ☐ M ☐ F	DOB:	Insurance/Medicare #:	Physician's Name:

SECTION II – TRANSPORT INFORMATION	
Pickup Address:	Drop Off Address:

SECTION III – MEDICAL NECESSITY QUESTIONNAIRE	
Primary Diagnosis:	Special Condition: • Bariatric • Extra Attendant Needed • Life Sustaining Oxygen

EXPLAIN IN DETAIL the condition of the patient requiring ambulance transportation instead of alternate transportation. If hospital-to-hospital transport, describe the service needed that is not available at the originating facility:

Check all appropriate boxes for the above named patient

- ☐ Unable to get out of bed without assistance, ambulate, and sit in chair, including wheelchair, due to other condition indicated in the narrative above
- ☐ Comatose or obtunded, requiring trained monitoring
- ☐ Dementia, Late Stage Alzheimer's, Severe Alerted Mental Status, decreased level of consciousness
- ☐ Frail, debilitated, extreme muscle atrophy, risk of falling out of wheelchair while in motion
- ☐ Suffers from paralysis or contractures Lower extremities _____ Fetal _____
- ☐ Requires oxygen Liters per minute _____ Self-administered? _____ Yes _____ No
- ☐ Requires airway monitoring or suctioning during transport
- ☐ Requires cardiac EKG monitoring
- ☐ IV maintenance required ☐ IV administered during transport _____ Yes _____ No
- ☐ Seizure prone and requires trained personnel to monitor
- ☐ Danger to self and others requires restraint verbal ____ chemical ____ physical ____ flight risk ____
- ☐ Has decubitus ulcers and requires wound precautions buttocks ____ sacral ____ back ____ hip ____
- ☐ Requires isolation precautions (VRE, MRSA, etc.) or other special handling

I certify that the above information is true and correct based on my evaluation of the patient. I understand that this information will be used by CMS to support the determination of medical necessity for ambulance service.

Printed Name: _____ Signature:_____ Date/Time _____

☐ Physician ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner ☐ Clinical Nurse Specialist ☐ Physician Asst.

A Physician Certification Statement (PCS) is required, pursuant to 42 CFR part 410.40 (d) (2) and (3), by the Centers for Medicare and Medicaid Services (CMS) on all non-emergency ambulance transports.

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