22 Tyler Street
Springfield, MA 01109

Main Line: (413) 209-8830
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PHYSICIAN'S CERTIFICATION STATEMET (PCS)

For Unscheduled & Scheduled Transportation

Please Select One:

[ ] Wheelchair Van [ ] BLS Ambulance [ ] ALS Ambulance *Paramedic Required*

SECTION 1: Beneficiary Information

Last Name_____ First Name_____ Date of Birth_____

Primary Insurance Type_____ Primary Ins. Policy # _____

SECTION 2: Transportation Information

Service Starting Date _____ Service Ending Date_____

Origin Location_____

Facility Floor/Unit Street Number Street City State Zip

Destination Location_____

Facility Floor/Unit Street Number Street City State Zip

Is this a **ROUND TRIP**? □ **YES** □ **NO** Is patient being **DISCHARGED**? □ **YES** □ **NO**

If transporting to Outpatient Dept. for what type of procedure? □ **DIALYSIS** □ **THERAPY** (type)_____ □ **DIAGNOSTIC** (type)_____

SECTION 3: Medical Necessity Information

In my professional opinion, this patient requires transportation by ambulance and should not be transported by any other means. The patient's condition is such that the use of any other mode of transportation would be contraindicated or would be potentially harmful to the patient. Ambulance transportation is medically necessary due to:

□ **YES; Unsafe to transport patient by car or wheelchair van** (i.e., seated during transport, without medical monitoring)

□ **YES; BED CONFINED DUE TO:** (EXPLAIN; specific bed confining injury / illness), (unable to get up from bed without assistance & unable to ambulate & unable to sit in chair)

In addition, YOU MUST CHECK AT LEAST ONE that applies;

Advanced Life Support (PARAMEDIC Required)

□ **Ventilator** Dependent (MD signature) □ **Cardiac** EKG Monitoring (MD signature) □ **IV Meds/Fluids** Administration (MD signature)

Monitoring Required

□ **Medicated/Sedated** & requires medical monitoring during transport □ **Medical Device** monitoring required (Due To; state condition below)

□ **Medical Condition** requires medical supervision: □ Jtube □ Gtube □ Woundvac □ Pump □ Other _____

Physical Issues

□ **Obesity Morbid** (requires specialized safe handling) □ **Airway Monitoring / Suctioning** (by EMT)

□ **Shortness of Breath** (oxygen administered & regulated by EMT) □ **Isolation / Infection Control Precautions** (MRSA, VRE, TB, HEP, C-Dif)

Mental Status Issues

□ Psychosis □ Suicidal/Homicidal □ Violent, Combative, Confused □ Restraints (phys/chem) □ Flight Risk / Psyc. Hold (danger to self/others)

Medical Issues

□ Altered Mental Status/Decreased Level of Consciousness □ Comatose/Vegetative

□ CVA/Stroke (recent or residual affecting ability to safely sit upright) □ Convulsions/Seizure Prone

Mobility Issues

□ **Amputation** (of lower limb recent) □ **Fracture** Immobilization (non-healing / hip precautions) □ **Decubitus Ulcers/Wounds** (explain)

□ **Pain** (moderate to severe on movement; explain below)

□ **Paralysis** □ Hemiplegic □ Paraplegic □ Quadriplegic

□ **Contractures** (of muscles, tendons, tissues) Locations: □ Arms □ Legs □ Fetal

□ **Orthopedic Device** requiring special handling: □ Halo, □ Backboard, □ Pins, □ Traction, □ Brace, □ Wedge, □ Other _____

□ **Unable to sit safely** upright / tolerate seated position for time needed during transport (Due To; state condition) _____

Describe the Medical Condition (physical and/or mental) at the time of Ambulance Transport that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition: _____

_____

_____

SECTION 4: Authorized Healthcare Professional Signature

Must be signed only by **MD/DO** for scheduled repetitive transports such as **Dialysis** and effective for **60 days**

I have reviewed the above certificate and I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport whether available or not are contraindicated, inadvisable, and potentially injurious to this patient. I certify that the information contained herein is, to be the best of my knowledge, complete and accurate and supported in the medical record of the patient. I understand that this information will be used by the Centers of Medicare and Medicaid Services to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

_____ _____ _____

Print Full Name Signature NPI # Date

□ **MD/DO Physician** □ **Physician Assistant** □ **Nurse Practitioner** □ **Registered Nurse** □ **Clinical Nurse Specialist** □ **Discharge Planner**