DEKALB AMBULANCE SERVICE *Dispatch Center Phone: 256.845.4027 Press 1*

PHYSICIAN'S CERTIFICATION STATEMENT (PCS) FOR AMBULANCE TRANSPORT

DATE OF TRANSPORT: ____/____/____ ❑ **ROUND TRIP CALL** ❑ **ONE WAY**

EVENT NUMBER: _____ **Please fax to 256.845.7740 (*Non-Rep Pts*)**

Patient Name Printed:	**DOB:**	**SSN:**
Sending Facility:	**Receiving Facility:**	
	Type of Insurance:	

OPTION 1: AMBULANCE MEDICALLY NECESSARY

A. In my professional medical opinion, this patient requires transport by ambulance and should **not** be transported by other means. The patient's condition is such that transportation by medically trained personnel OR a stretcher is required. Ambulance transport is required because:

❑ Bedbound : The CMS definition of *bedbound* is the inability to get up from bed without assistance, the inability to ambulate, **and** the inability to sit in a chair, including wheelchair.
Why is the patient BEDBOUND: _____

❑ Needs continual Medical Supervision: This patient needs continual medical supervision and transport by other means may place the patient's general welfare in jeopardy or cause impairment of bodily function. Why: _____

❑ ALS Care Required Due to *current or potential condition*, an ALS (IV, ETT, EKG, etc.) attendant is required.

B. Describe current *physical* condition of patient that makes transportation by ambulance medically necessary:

_____

_____

C. Please check any of the following that apply: ❑ Altered Mental Status - GCS= ___; ❑ Persistent Vegetative State
❑ Decubitus Stage III or IV, Where: _____; ❑ Hemiplegia; ❑ Paraplegia; ❑ Quadraplegia; ❑ Body Rigidity;
❑ No trunk control; ❑ PEG tube; ❑ TRACH tube; ❑ Requires chemical restraint; ❑ On Oxygen Therapy; ❑ IV Infusing;
❑ Contractures: Where: _____; ❑ Flexion precautions; ❑ Risk of pathological fractures; ❑ Needs cardiac monitoring

OPTION 2: AMBULANCE NOT MEDICALLY NECESSARY

_____ (Physicians Initials) In my professional medical opinion, this patient **DOES NOT REQUIRE TRANSPORT BY AMBULANCE** and can safely be transported by other means because the patient can safely support him/herself while seated in wheelchair or car and does not require monitoring by trained personnel.

❑ This transfer is at the request of the patient or representative and is not medically necessary that he/she be transferred.

HOSPITAL TO HOSPITAL TRANSFER ❑ YES ❑ NO Is this a medically necessary transfer for an UPGRADE in the patient's care?

CHECK ALL THAT APPLY

❑	Appropriate MD or Surgeon not available
❑	Surgery/Procedure not performed here
❑	Bed not available here
❑	Equipment and/or personnel are not available at this hospital

CMS requires that ambulance providers obtain a signed Physician's Certification Statement for non-emergencies or the claim cannot be filed. This form has been designed to assist the physician, the Medicare beneficiary and the ambulance provider to determine that medical necessity has been met with this transport . Failure to obtain this form may place the obligation for payment on the beneficiary.

The responsibility for completion of the form rests with the physician per Medicare and should be with the patient's medical records at the time of transport or transfer.

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

Signature of Physician: _____ Physician Name Printed: _____ Date: ___/___/____

If a physician is unable to sign, please check the appropriate box who signs this form below: ❑ P.A. ❑ R.N.,
❑ Discharge Planner, ❑ CNS, or ❑ CRNP.

Signature : _____ Date: _____/_____/_____

Printed Name of above signature: _____ **Rev 5 NOV 2010**