



AMBULANCE PCS



Physician Certification Statement For Ambulance Transportation

Section 1 – Beneficiary Information

Patient Name:	Diagnosis:
Date of Transport:	Medicare/Medicaid #:
Pickup:	Destination:

Section 2 – Medical Necessity Information for non emergency transportation.

Can the patient be safely transported by car, taxi, bus or a wheelchair van (seated for the duration of the transport, and without a medical attendant)? Yes No **If yes, the patient does not meet the criteria for stretcher transportation.**

Please describe the reason(s) why the patient required monitoring and/or transport by stretcher.

1. Is the beneficiary able to get up from bed without assistance? Yes No
2. Is the beneficiary able to ambulate? Yes No
3. Is the beneficiary able to sit in a chair or wheelchair? Yes No

Section 3 – For Hospital to Hospital Transfers Only

Is the patient being transferred to a higher level of care? Yes No

(A) Please list/describe facilities or procedures required/available at destination facility not available at originating facility?

(B) Was the patient discharged at originating facility either as an inpatient or outpatient? Yes No

(C) Is the patient being transported to the closest appropriate facility? Yes No
If no, describe why the patient has to be transported to the further facility.

If the patient is not being transported to the closest appropriate facility, has the patient/family been notified they will be responsible for the additional mileage beyond the closest appropriate facility?
Yes No

(D) Is the patient Critically ill or Injured, Unstable, or in Need of Immediate Interventions? Yes No

(E) If air ambulance is required, describe why the patient cannot be transported by **ground** ambulance.

Section 4

Print the name of the Physician or Health Care Professional ordering transportation: _____ **NPI:** _____

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 CMS to support the determination of medical necessity.

If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36 (b) (4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is incapable of signing the claim form is: _____

Signature of Physician* or Healthcare Professional _____ Date _____

*Physician must sign for scheduled or repetitive transports. For unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (check appropriate box below).

Physician RN Discharge Planner Nurse Practitioner PA Clinical Nurse Specialist