COMMUNITY AMBULANCE

PHYSICIAN CERTIFICATION STATEMENT (PCS)
FOR AMBULANCE TRANSPORT

Please Fax to

702-982-0326

Patient Name:_____ Date of Service:_____

Patient Transported From:_____ Patient Transported To:_____

Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. Supporting documentation for any boxes checked must be maintained in the patient's medical records.

Check all that apply (at least one of the reasons below must be checked to deem transport a medical necessity)

- Bed Confined * **<u>All three below must be met to qualify for bed confinement</u>**
  - Unable to ambulate*
  - Unable to get out of bed without assistance*
  - Unable to safely sit up in a wheelchair* (Check one below if patient bed confined)
    - Unable to maintain erect sitting position in a chair for time needed to transport due to moderate muscular weakness and de-conditioning.
    - Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- Third party assistance/attendant required to administer, regulate, or adjust High flow oxygen enroute
- I.V. medications/fluids required during transport
- Cardiac/Hemodynamic monitoring required during transport
- Special Handling enroute - Isolation
- Contractures
- Non-healed fractures
- Moderate to severe pain on movement
- DVT requires elevation of a lower extremity
- Morbid Obesity requires additional personnel/equipment to handle
- Orthopedic device (backboard, halo, etc.) requiring special handling in transit
- Severe muscular weakness or deconditioned state precludes any significant physical activity
- Restraints (physical or chemical) required or anticipated to be used during transport
- Danger to self or others - monitoring
- Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- Danger to self or others - seclusion (flight risk)
- Confused , combative, lethargic, comatose
- Other:_____
- Other:_____

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.

Signature:_____

Printed Name:_____

Date of Signature:_____

- ❑ Patient's Physician
- ❑ Physician Assistant
- ❑ Nurse Practitioner
- ❑ Clinical Nurse Specialist
- ❑ Discharge Planner
- ❑ Registered Nurse

For unscheduled or scheduled non-repetitive transports the authorization may be signed by the attending **physician, physician assistant, clinical nurse specialist, nurse practitioner, registered nurse, or discharge planner** (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished. This authorization must be completed and signed by the **<u>attending physician</u>** for scheduled repetitive transports. PCS form is good for 60 days only if signed by attending physician.