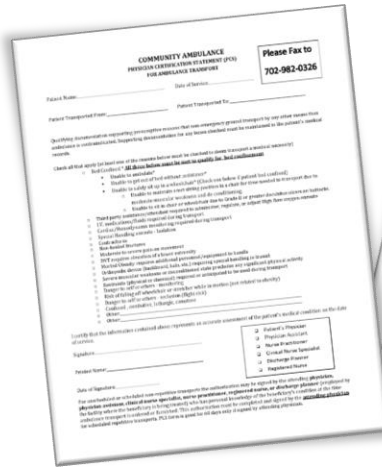


JULY 2020



Dispatch:  
702-222-9111

DOING GOOD IN THE COMMUNITY



## PCS Forms

We wanted to take the time to thank all of the facilities that diligently help us with PCS (Physician Care Statement) forms for patients transported that have Medicare.

These forms help provide Medicare proof that ambulance transport was medically necessary for a patient.

- Federal Medicare requires ambulance services to follow the federal fee schedule for Basic Life Support, Advanced Life Support and Critical Care Transport levels of service. Payments for these fees are subject to patients' medical necessity.
- Medicare cannot be billed for a non-emergency transport where the patient is under the direct care of a physician without a valid PCS Form.
- As an ambulance provider in Southern Nevada, we do not set rates. These rates are set by the municipalities of City of Las Vegas, Henderson, and Clark County.

Answers to a few commonly asked questions:

- For a copy of our PCS form, one can be found on the back of this page, please email me at [stachyra@communityambulance.com](mailto:stachyra@communityambulance.com), or visit us online at

[www.communityambulance.com/facility-updates](http://www.communityambulance.com/facility-updates)

- Form can be faxed to 702-982-0326
- Bedridden alone usually does not qualify for Medicare payment. In these instances, it is best to use that in combination with "Other" - listing why the patient requires attendant monitoring.
- If a transport is denied by Medicare, we then bill the patient.

We are committed to do our best to keep everyone safe. We look forward to providing your patients a continuity of excellent care. We genuinely appreciate the important work you do and the assistance you provide us. Please let me know if you have any questions about our company and/or our billing rules and regulations.

### CONTACT US

Administrator on Call (24 Hours)

702-222-9111

Chris Stachyra 702-816-1959



Scan the above QR Code with the camera on your phone to get our latest updates and access to the PCS form directly!

**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 \* **All three below must be met to qualify for bed confinement**
  - 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 **attending physician** for scheduled repetitive transports. PCS form is good for 60 days only if signed by attending physician.