

PHYSICIAN CERTIFICATION STATEMENT (PCS)
For all Ambulance Transports of MEDICARE Patients
Please Print Legibly

MR # _____ Acct # _____
Patient Name: _____
DOB: _____

Transport Date: _____

Facility Provider's Printed Name: _____

Patient's Medicare #: _____

MEMS Run #: _____

Transported From: _____

Transported To: _____

If transport is not to closest appropriate facility, explain reason to transport to the farther facility: _____

Note: Medicare will not consider it medically necessary if patient or provider preference is sole reason for distant facility

Medical Condition of Patient (diagnosis/symptoms/chief complaint): _____

Check either Option 1 or Option 2 and appropriate checkoff boxes/lines:

 OPTION 1

In my professional medical opinion, this patient does not/did not require transport by ambulance and can be/could have been safely transported by other means. The patient's condition is such that transportation by ambulance is not required because the means listed below would be safe and acceptable. (*Requires NEMB form if patient is to be transported by ambulance.*)

- Patient can safely support him/herself while seated in a wheelchair and does not require monitoring by trained personnel
- Patient is able to tolerate transportation by automobile, taxi or wheelchair van (whether available or not)

--OR--

 OPTION 2

In my professional medical opinion, this patient requires/required transport by ambulance and not by any other means. The patient's condition is/was such that transportation by medically trained personnel is/was required. Includes for patients transported in an emergency due to an injury, accident or illness where transport is required by local EMS protocols or appropriate medical judgment.

For Transfers under Option 2:

THE CMS DEFINITION OF "BED-CONFINED" FOR AMBULANCE TRANSPORTS IS:
"UNABLE TO GET UP FROM BED WITHOUT ASSISTANCE AND UNABLE TO AMBULATE AND
UNABLE TO SIT IN A CHAIR OR WHEELCHAIR"

Is the patient bed-confined as defined by the CMS Ambulance Regulation above? YES NO

If NO, please check all appropriate medical condition(s) listed below which would necessitate transport by ambulance and make all other means of transportation contraindicated based on patient safety and health.

This patient:

- | | |
|---|---|
| <input type="checkbox"/> Requires ventilation | <input type="checkbox"/> Has decubitus ulcers and requires wound precautions |
| <input type="checkbox"/> Requires airway monitoring and suction | <input type="checkbox"/> Requires isolation precautions (VRE, MRSA, etc) |
| <input type="checkbox"/> Requires restraints or sedation | <input type="checkbox"/> Requires continuous IV therapy |
| <input type="checkbox"/> Is comatose and requires trained monitoring | <input type="checkbox"/> Requires cardiac monitoring |
| <input type="checkbox"/> Is actively seizure prone and requires trained monitoring | <input type="checkbox"/> Is exhibiting signs of decreased level consciousness |
| <input type="checkbox"/> Has to remain immobile due to fracture or possible fracture | <input type="checkbox"/> Is on hip precaution and cannot sit safely |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> (MH) Requires trained monitoring for patient safety |
| <input type="checkbox"/> Requires continuous or potential medication administration and monitoring by trained EMS staff | |
| <input type="checkbox"/> Other: _____ | |

Fax to NorthStar Billing: **235-2223**

Signature of Provider*: _____ Date: _____ Time: _____

*A physician must sign for all emergency transports and non-emergency repetitive scheduled transports.
MD, DO, PA, NP, RN or Discharge Planners are acceptable signatories for non-emergency non-repetitive transfers.