Physician Certification Statement for Medical Necessity

A Physician Certification Statement (PCS) is required, pursuant to 42 C.F.R. 410.40(d)(2) and (3), by the Centers for Medicare/Medicaid (CMS) on all scheduled and unscheduled non-emergency transports.

Please print clearly and have physician sign where indicated below. Complete ALL sections of this form.
See reverse for important information on completing this form.

Section 1 - Beneficiary Information

Name: Last Name	First Name	Middle Initial

Diagnosis

DOB:	Sex	SSN

Date of Transport ______/______/______	❑ If multiple transports required (Dialysis, Radiation, etc.)? Check here to validate this PCS for Maximum of 60 Days. ________________ Initial

Section 2 - Transportation Information

Transport From:	Unit/Bed	Discharge? ❑Yes ❑No
Transport To:	Unit/Bed	Admit? ❑Yes ❑No

Section 3 - Medical Necessity

Please check the appropriate medical condition(s) listed below which would necessitate transport by ambulance and make all other means of transport contraindicated based on patient safety and health. PLEASE CHECK ALL THAT APPLY.

❑ **Bed Confined:** All three criteria below must be met to quality for bed confinement.

1. Unable to ambulate.
2. Unable to get out of bed without assistance.
3. Unable to safely sit up in a wheelchair.
   a. Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning.
   b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers.
   ❑buttocks ❑coccyx ❑hip ❑other

❑ **Morbid Obesity** requires additional personnel / equipment to handle.
❑ Suffers from **paralysis**: ❑ hemi ❑ quad ❑ para
❑ Patient has **contractures**: ❑ upper ❑ lower ❑ both
❑ Patient has non-healed **fractures**. Location: ____
❑ Exhibiting signs of a **decreased level of consciousness**: ❑ confused ❑ combative ❑ lethargic ❑ comatose
❑ **DVT** requires elevation of a lower extremity.
❑ **Seizure** prone and requires trained monitoring.
❑ Patient requires **Isolation Precautions**; reason ____
❑ **IV** medications/fluids required during transport.
❑ **Cardiac** / Hemodynamic monitoring required during transport. Specify: ____
❑ **Orthopedic device** (backboard, halo, use of pins in traction, etc.) requiring special handling during transport.
❑ Patient requires **airway** monitoring or suctioning. ❑ Portable ventilator required.
❑ Trained personnel required for administering, and/or regulating **oxygen** en route.
❑ Patient is a **danger to self or others** (requires monitoring).
❑ Restraints (physical or chemical) anticipated or used during transport.
❑ Patient requires elopement precautions (flight risk).
Please list any Medical Hx / Dx which can help substantiate the above conditions: ____

Other Conditions not listed above:

Section 4 - Ordering Physician Information and Signature

Print Name of Physician Ordering Ambulance Services:		I certify that the above information is true and correct based on my evaluation of this patient. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance service.
Physician's Signature Date	AND/OR	Medical Support Staff Signature Date

From transports done by Pridemark Paramedic Services, you may fax to (303) 432-1941