

REPETITIVE PATIENT

(AMBULANCE) PHYSICIAN CERTIFICATION STATEMENT FOR MEDICAL NECESSITY



www.beaumontmedicaltransportation.org

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

***Sections 1 - 3 MUST be completed in order for the form to be compliant with state and federal billing regulations.**

Section 1	PATIENT NAME:		DOB:	MEDICARE/MEDICAID ID:
	TRANSPORTED FROM:	TRANSPORTED TO:		ROUND TRIP? <input type="checkbox"/> YES <input type="checkbox"/> NO
	DATE(s) OF SERVICE:	ORDERING PHYSICIAN'S PRINTED NAME:		ORDERING PHYSICIAN'S NPI:

PLEASE PROVIDE DOCUMENTATION OF THE PATIENT'S MEDICAL CONDITION AT THE TIME OF TRANSPORT TO SUBSTANTIATE AMBULANCE MEDICAL NECESSITY.

Section 2	<p><u>All three criteria</u> below must be met to qualify for "bed confinement".</p> <p>1. Unable to ambulate. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Unable to get out of bed without assistance. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Unable to safely sit up in a wheelchair: <input type="checkbox"/> YES <input type="checkbox"/> NO *if YES, complete 3-A. & 3-B.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers. buttocks _____ coccyx _____ hip _____ other _____</p> <p>**Under Medicare/Medicaid regulations, diagnosis of bed confinement by itself does not substantiate medical necessity</p>
	<p>Please list any Medical Hx / Dx, which substantiates transportation by ambulance, is medically required: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

FOR REPETITIVE PATIENTS (E.G., DIALYSIS PATIENTS) THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY A PHYSICIAN AS SET FORTH IN 42 C.F.R. §410.40(D)(2). FAILURE TO RETURN THE REQUIRED DOCUMENTATION MAY RESULT IN AN INTERRUPTION OF SERVICE AND MAY CAUSE A FINANCIAL BURDEN TO THE PATIENT

Section 3	Physician Certification / Authorization: I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.	
	Physician's Printed Name & Licensure:	
	Physician Signature:	Date Signed:

The Physician Certification Statement is valid for 60 days from the date of the physician's signature.