Beaumont Mobile Medicine

**Dispatch 866-601-2687**
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# AMBULANCE TRANSPORTATION
# 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 and Medicaid (CMS) on all scheduled and unscheduled non-emergency transports. (Please see below for signature requirements)**

***Sections 1 - 4 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?** ☐ YES ☐ NO |
| **TYPE OF TRANSPORT:** ☐ ALS ☐ BLS | **FREQUENCY OF TRANSPORT:** | **TYPE OF ONGOING TREATMENT:** |
| **DATE(s) OF SERVICE:** | **ORDERING PHYSICIAN'S PRINTED NAME:** | **ORDERING PHYSICIAN'S NPI:** |

## Section 2

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

☐ Paralysis: Hemi _____ Quad _____ Para _____
☐ Unstable fractures
☐ Contractures: Upper _____ Lower _____ Both _____
☐ DVT requires elevation of a lower extremity
☐ Moderate/severe pain on movement
☐ Restraints (physical or chemical) anticipated or used during transport
☐ Dementia ☐ Intermittent Confusion ☐ Persistent Confusion
☐ Patient is confused, combative, lethargic, or comatose.
☐ IV meds/fluids required: _____
☐ Ventilator Required
☐ Cardiac/hemodynamic monitoring required enroute
☐ Chest Tube
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling
☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Assistance/attendant required to apply, administer or regulate **oxygen** enroute

**Other:** _____

**Common ED Reasons:**

☐ **Higher Level of Care**: *(list the reason)*
- ☐ Chest Pain
- ☐ Acute MI
- ☐ ICB
- ☐ Stroke
- ☐ Multiple trauma,(list injuries): _____

☐ **Specialty Care:** *(list the reason)*
- ☐ Danger to self or others
- ☐ Psychiatric Dx: _____
- ☐ Elopement Precautions
- ☐ Peds: _____

☐ Other: _____

## Section 3

**All three criteria below must be met to qualify for "bed confinement".**

1. Is the patient unable to ambulate? ☐ YES ☐ NO
2. Is the patient unable to get out of bed without assistance? ☐ YES ☐ NO
3. Is the patient unable to safely sit up in a wheelchair? ☐ YES ☐ NO *if YES, complete 3-A. & 3-B.

☐ 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 _____

**Is the patient bed confined?** ☐ **Yes** ☐ **No**
Please check or list the condition resulting in bed confinement above in section 2.

## Section 4

**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.**

| | | | |
|---|---|---|---|
| **Printed Name W/Credentials:** | | | |
| **Title**: | ☐ Attending Physician<br>☐ Nurse Practitioner | ☐ Physician Assistant<br>☐ Registered Nurse | ☐ Clinical Nurse Specialist<br>☐ Discharge Planner |
| **Authorized Signature:** | | **Date Signed:** | |

**Medicare and Medicaid regulations state that only a Physician, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse, or discharge planner may sign the physician certification statement form.**