Physician's Certification Statement (PCS)

Revised October 31, 2012

Nonemergency Ambulance Transportation - MEMS

Dispatch: 301-1407, Office 301-1400, FAX 301-1436

MEMS Run Number: ______________

Patient Name: ______________ Date of Transport: ______________

Social Security: ______________ Transport From: ______________

Date of Birth: ______________ Transport To: ______________

Medicare ID: ______________ Private Insurance: ______________

Medicaid ID: ______________ Policy / Group: ______________

Medical necessity for nonemergency ambulance transportation requires that a patient either be bed confined or require medical care during the ambulance transport. Medicare's definition of bed confinement is printed at the bottom of this form. Note that bed confinement can be due to a current condition such as decubitus or a reduced level of consciousness, or a patient can be bed confined by a chronic condition such as contractures. Please check all areas that apply to this patient. Use the narrative area below for additional comments on the medical necessity of ambulance transportation for this patient.

Check one: Patient is Bed Confined ☐ Patient Requires Care During Transport ☐

Patient is Bed Confined		Patient Requires Care During Transport	
Immobilization	☐ Fall Risk ☐ Post Op ☐ Pain - Scale ____ ☐ Fracture ____ ☐ Risk Additional Injury	Monitoring	☐ IV ☐ Airway Suctioning ☐ Medicated ☐ EKG ☐ Oxygen_____lpm ☐ Seizure Prone
Reduced Consciousness	Verbal / Pain / Unresponsive ☐ Dementia ☐ Sedated ☐ Coma ☐ Fever____ °	Restraints	☐ Chemical ☐ Verbal ☐ Danger to Self ☐ Physical ☐ Flight Risk ☐ Danger to Others
Decubitus	☐ Coccyx ☐ Sacral ☐ Feet Stage ____ ☐ Hips ☐ Back ☐ Other ____	Isolation	☐ MSRA ☐ Meningitis ☐ Surgical Drainage ☐ VRE ☐ Tuberculosis ☐ Other ____
Contractures	☐ Lower ☐ Fetal Early / Moderate / Severe ☐ Upper ☐ ____	Other Care	☐ Morbid Obesity. ⇨ Weight ____ ☐ Vent Dependent ☐ Other (Use Narrative Below)
Musco-Skeletal	☐ Neuropathy Early / Moderate / Severe ☐ Parkinsons	Reason for Trip	☐ Testing ⇨ ☐ Treatment ⇨ ____
	☐ Cerebral Palsy ☐ Rheumatoid Arthritis ☐ Muscle Atrophy ☐ Osteoporosis	Discharged After	☐ Procedure ⇨ ☐ Evaluation ⇨ ____

Hospital Discharge Out of Town. Must Note Treatment Provided at Originating Hospital

Hospital to Hospital Transfer. Must Note Elevated Care Needed at Destination Hospital ☐ Cardiac Cath ☐ Psychiatric ☐ Surgery ⇨ ____ ☐ Angiogram ☐ Long Term Rehab ☐ Other ⇨ ____

Patient Condition / Narrative

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand this information will be used by the Center for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I am a representative of the institution named below. I certify that our institution has furnished or is furnishing care or other services to the above named patient. In the event you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf. This is NOT an acceptance of financial responsibility for this transport.

______________ ______________

Signature (circle one) of MD, PA, RN, RNP, CNS, or Discharge Planner — Date

NOTE: Medicaid beneficiaries require MD or Physician's signature

______________ ______________

Printed Name of Person Signing Document — Facility / Institution Name

If Bed Confined and destination is a private residence, care transferred to: ______________

Telephone number of person to whom care will be transferred: ______________

Definition of Bed Confined: (1) The beneficiary is unable to get up from bed without assistance, (2) The beneficiary is unable to ambulate, and (3) The beneficiary is unable to sit in a chair or wheelchair. (Medicare Provider Manual)