Physician's Certification Statement (PCS)

Nonemergency Ambulance Transportation - MEMS

Revised November 23, 2016

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

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

Immobilization ☐ Fall Risk ☐ Post Op ☐ Pain - Scale _____
☐ Fracture _____ ☐ Risk Additional Injury

Reduced Consciousness Verbal / Pain / Unresponsive
☐ Dementia ☐ Sedated ☐ Coma ☐ Fever___°

Decubitus ☐ Coccyx ☐ Sacral ☐ Feet Stage _____
☐ Hips ☐ Back ☐ Other _____

Contractures ☐ Lower ☐ Fetal Early / Moderate / Severe
☐ Upper ☐ _____

Musco-Skelatal ☐ Neuropathy Early / Moderate / Severe
☐ Parkinsons
☐ Cerebral Palsy ☐ Rheumatoid Arthritis
☐ Muscle Atrophy ☐ Osteoporosis

Monitoring ☐ IV ☐ Airway Suctioning ☐ Medicated
☐ EKG ☐ Oxygen ____lpm ☐ Seizure Prone

Restraints ☐ Chemical ☐ Verbal ☐ Danger to Self
☐ Physical ☐ Flight Rist ☐ Danger to Others

Isolation ☐ MRSA ☐ Meningitis ☐ Surgical Drainage
☐ Physical ☐ Tuberculosis ☐ Other _____

Other Care ☐ Morbid Obesity ➡ Weight _____
☐ Vent Dependent ☐ Other (Use Narrative Below)

Reason For Trip ☐ Testing ➡
☐ Treatment ➡ _____

Discharge After ☐ Procedure ➡
☐ Evaluation ➡ _____

Facility agrees to pay for this transport. Name of facility: _____

Signature of person authorising payment: _____ Printed Name: _____

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

Hospital to Hospital Transfer. Must Note ☐ 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
NOTE: Medicaid beneficiaries require MD or Physician's signature

Date

_____ _____

Printed Name of person Signing Document

Facility / Institution Name

If Bed Confined and destination is a private residence, care transport 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)