Run # _____

Physician Certification Statement (PCS)
24 Hour Dispatch: (810) 742-5449
Secure Fax: (810) 600-2418 or (810) 742-5366

Patient Name: _____ **Date of Birth:** _____

Transport Date: _____ **Certification Exp Date (Max 60 Days):** _____

Origin: _____ **Destination:** _____

The following must be answered by the medical professional signing below for this form to be valid.

Medical diagnosis that requires ambulance transport: _____

Patient is bed confined: ☐ **YES** ☐ **NO** CMS Definition: (Must meet all criteria) Unable to get up from bed without assistance, unable to ambulate, and unable sit in a chair or wheelchair.

Check all that apply:

☐ Patient is ventilator dependent
☐ Patient requires airway monitoring or suctioning
☐ Requires continuous oxygen & monitoring by trained staff
☐ Requires cardiac monitoring or IV maintenance
☐ Patient is comatose & requires trained monitoring
☐ Seizure prone & requires trained monitoring
☐ Exhibiting signs of decreased level of consciousness
☐ Moderate / severe pain on movement
☐ Paralysis (Hemi, Semi, Quad)
☐ Contractures (upper, lower)
☐ Fracture: _____
☐ Has decubitus ulcers & requires wound precautions
☐ Requires isolation precautions (VRE, MRSA, etc.)
☐ Medical attendant required
☐ Requires psychiatric care (danger to self or others, flight risk)
☐ Need or possible need for restraints
☐ Should not stand, pivot, ambulate, has a limited range of motion, or is unable to safely assist with moving
☐ Can tolerate wheelchair but inadvisable due to patient's safety and/or condition
☐ Other Reasons:

_____

_____

Transfer from Facility to Facility:
☐ Patient requires specialty physician not available at the current facility: (Describe)

_____

☐ Patient requires special services not available at the current facility: (Describe)

_____

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. 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 services, and I represent that I have personal knowledge of the patient's condition at the time of transport.
☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

Print Name: _____ Signature: _____

Date Signed: _____ Physician NPI: _____

☐ **Physician** ☐ **Physician Assistant** ☐ **Nurse Practitioner** ☐ **Registered Nurse** ☐ **Discharge Planner** Effective 01/2019