Run # _____

Physician Certification Statement (PCS)

Office: (810) 742-5391
Secure Fax: (810) 600-2418

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

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

Pick Up: _____ **Drop Off:** _____

Medical Diagnosis That Requires Ambulance Transport: _____

YES or NO (Circle One)

CMS Definition: Inability to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair. (Must meet all criteria)

Check all that apply:

- ☐ Patient is Ventilator dependent
- ☐ Patient requires airway monitoring or suctioning
- ☐ Requires cardiac monitoring or IV maintenance
- ☐ Patient is comatose & requires trained monitoring
- ☐ Seizure prone & requires trained monitoring
- ☐ Exhibiting signs of decreased level of consciousness
- ☐ Paralysis (Hemi, Semi, Quad)
- ☐ Requires psychiatric care (danger to self or others, flight risk)
- ☐ Can tolerate wheelchair but inadvisable due to Pt's safety &/or condition
- ☐ Other Reasons:

_____

_____

- ☐ Requires continuous oxygen & monitoring by trained staff
- ☐ Contractures (upper, lower)
- ☐ Fracture: _____
- ☐ Has Decubitus Ulcers & requires wound precautions
- ☐ Requires isolation precautions (VRE, MRSA, etc)
- ☐ Requires restraints
- ☐ Should not stand, pivot, or ambulate or is unable to safely assist with moving

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
- ☐ Discharge Planner
- ☐ Nurse Practitioner
- ☐ Registered Nurse
- ☐ Social Worker

Effective 03/2016