Email: Scheduling@patriotambulance.net
Secure fax: (810)742-5366

IS THIS PATIENT IN THEIR MEDICARE "PART A" STAY?
YES ☐ **NO** ☐

TRANSPORT REQUEST	
PATIENT NAME:	DOB: / /
HEIGHT:	**WEIGHT:**
PICKUP LOCATION:	
PICKUP ADDRESS:	ROOM#:
DATE OF TRANSPORT:	TIME OF APPT:
DESTINATION NAME	PHONE #:
DEST. ADDRESS:	SUITE
NOTES:	

TYPE:	✔ **AMBULANCE**	☐ **BARIATRIC**	
EQUIPMENT:	☐ **TRACH - (OPEN) or (CAPPED)**	☐ **ISOLATION:** _____	
	☐ **VENT - (HAS) or (NEEDS)**	☐ **CARDIAC MONITOR**	
	☐ **OXYGEN -LPM:** _____	☐ **IV PUMP - (HAS) or (NEEDS)**	

Run # _____

Physician Certification Statement (PCS)
24 Hour Dispatch: (810) 742-5449

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 oxygen airway monitoring or suctioning
- ☐ Fracture: _____
- ☐ Requires cardiac monitoring or IV maintenance
- ☐ Requires isolation precautions (VRE, MRSA, etc.)
- ☐ Medical attendant required
- ☐ Paralysis (Hemi, Semi, Quad)
- ☐ Contractures (upper, lower)
- ☐ Exhibiting signs of decreased level of consciousness
- ☐ Has decubitus ulcers & requires wound precautions
- ☐ Seizure prone & requires trained monitoring
- ☐ Requires psychiatric care (danger to self or others, flight risk)
- ☐ Should not ambulate, has a limited range of motion, or is unable to safely assist with moving

Transfer from Facility to Facility:
Patient requires special physician/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** ☐ **RN** ☐ **LPN** ☐ **Discharge Planner** ☐ **Social Worker** Effective 07/2024