NON-REPETITIVE PATIENT

Physician Certification Statement (PCS)

LIFEGUARD AMBULANCE SERVICE

Physician's Name: _____	**Patient's Name:** _____	***LGAS USE ONLY:***
Phone #: _____	Medicare/Insurance #: _____	*Transport Date:*
Fax #: _____	Medicaid Auth #: _____	*Run #:*
Pick Up Location: _____	**Drop Off Location:** _____	

1. This form must be completed in its entirety.
2. The patient's condition ***at the time of transport*** must be documented.
3. Medical Necessity criteria must be clearly documented according to CMS PCS requirements.
4. ***If patient is a repetitive patient, complete the repetitive patient PCS form.***

Medicare requires under 42 C.F.R., Part 401.40(d) that ambulance providers obtain a Physician's Certification Statement (PCS), signed by a listed clinician, for the provision of non-emergency transportation. This form has been designed to assist clinicians, Medicare beneficiaries, and ambulance provider in determining if medical necessity has been met. Authorized signers please complete the medical necessity section of this form and then sign the form, listing your credential.

Under 42 C.F.R., Part 410.40(d)(1), Medicare establishes a beneficiary as bed-confined if they are:

ALL THREE conditions must be met at the time of transport.

1. Unable to get up from bed without assistance, **AND**
2. Unable to ambulate, **AND**
3. Unable to sit in a chair or wheelchair

MEDICAL NECESSITY CRITERIA

To be completed by a clinician who is employed or contracted by the facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was being furnished.

- ☐ Requires continuous oxygen, airway monitoring, or suctioning
- ☐ Is comatose and requires monitoring
- ☐ Is seizure prone and requires monitoring
- ☐ Has an unrepaired or recent fracture/joint replacement and is unable to bear weight and must remain immobile
- ☐ Is ventilator dependent
- ☐ Requires continuous IV therapy
- ☐ Requires EKG cardiac monitoring
- ☐ Patient has severe contractures: *upper:* ☐ *lower:* ☐ *both:* ☐
- ☐ Requires isolation precautions: *VRE:* ☐ *MRSA:* ☐ *CDIFF:* ☐ *Other:* _____
- ☐ Pain Medication, given prior to transport, needs continuation of care and advanced cardiac life support monitoring
- ☐ Exhibiting signs of a decreased level of consciousness/ awareness and is danger to self or others: *confused:* ☐ *combative:* ☐ *lethargic:* ☐ *comatose:* ☐
- ☐ Has decubitus ulcers and requires wound precautions/special handling. ***Define stage & location:*** *buttocks:* ☐ *coccyx:* ☐ *hip:* ☐ *other, list:* _____
- ☐ Requires restraints and/or sedation
- ☐ Patient requires services not available at this healthcare facility. ***Describe services***: _____
- ☐ Patient is bed confined. ***Describe patient's condition resulting in bed-confinement status***: _____

Provide any additional information on patient's condition, resulting in need for ambulance transport. Narrative and/ or ICD-10 codes accepted: _____

☐ MD ☐ DO ☐ ARNP
☐ PA ☐ RN ☐ CNS
☐ Discharge Planner

Clinician's Name: _____
Clinician's Signature: _____
Date: _____