

**NON-REPETITIVE PATIENT**

Physician Certification Statement (PCS)



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

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: <i>upper:</i> _____ <i>lower:</i> _____ <i>both:</i> _____ _____ 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: <i>confused:</i> _____ <i>combative:</i> _____ <i>lethargic:</i> _____ <i>comatose:</i> _____	_____ Has decubitus ulcers and requires wound precautions/special handling. <b><i>Define stage &amp; location:</i></b> <i>buttocks:</i> _____ <i>coccyx:</i> _____ <i>hip:</i> _____ <i>other, list:</i> _____ _____ Requires restraints and/or sedation _____ Patient requires services not available at this healthcare facility. <b><i>Describe services:</i></b> _____ _____ _____ Patient is bed confined. <b><i>Describe patient's condition resulting in bed-confinement status:</i></b> _____ _____ _____ _____ <b><i>Provide any additional information on patient's condition, resulting in need for ambulance transport. Narrative and/or ICD-10 codes accepted:</i></b> _____ _____ _____ _____
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_____ MD _____ PA _____ Discharge Planner	_____ DO _____ RN	_____ ARNP _____ CNS	<b>Clinician's Name:</b> _____ <b>Clinician's Signature:</b> _____ <b>Date:</b> _____
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