LIFEGUARD AMBULANCE SERVICE

REPETITIVE PATIENT

(Ambulance) Physician Certification Statement for Medical Necessity

A Physician Certification Statement (PCS) is required, pursuant to 42 C.F.R. 410.40(d)(2) and (3), by the Centers for Medicare/Medicaid (CMS) on all scheduled and unscheduled non-emergency transports.

FOR REPETITIVE PATIENTS (E.G. DIALYSIS PATIENTS), THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY A PHYSICIAN. FAILURE TO RETURN THE REQUIRED DOCUMENTATION MAY RESULT IN AN INTERRUPTION OF SERVICE AND MAY CAUSE A FINANCIAL BURDEN TO THE PATIENT.

The Physician Certification Statement is valid for 60 days from the date of the physician's signature.

DATE(s) OF SERVICE: _____ PATIENT NAME: _____ DOB: _____

PICKUP LOCATION: _____

DIALYSIS FACILITY: _____ WOUND CARE FACILITY: _____

Please check the appropriate medical condition(s) listed below, if applicable, which would necessitate transport by ambulance and make all other means of transport contraindicated based on patient safety and health. **PLEASE CHECK ALL THAT APPLY.**

☐ **Bed Confined:** All three criteria below must be met to qualify for bed confinement.

1. Unable to ambulate
2. Unable to get of bed without assistance
3. Unable to safely sit up in a wheelchair
   - Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning
   - Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers

   buttocks: ☐ *coccyx*: ☐ *hip*: ☐ *other, list*: _____

☐ **Morbid Obesity:** requires additional personnel/equipment to handle

☐ Suffers from **Paralysis:** *hemi*: ☐ *quad*: ☐ *para*: ☐

☐ Patient has **Contractures:** *upper*: ☐ *lower*: ☐ *both*: ☐

☐ Patient has non-healed **Fractures:** Location: _____

☐ Exhibiting signs of a **decreased level of consciousness:**

confused: ☐ *combative*: ☐ *lethargic*: ☐ *comatose*: ☐

☐ **DVT** requires elevation of a lower extremity

☐ **Seizure** prone and requires trained monitoring

☐ Patient requires **Isolation Precautions,** reason: _____

☐ **Required during transport:** IV Medications ☐ IV Fluids ☐ Cardiac Monitoring ☐ Hemodynamic Monitoring ☐

☐ **Orthopedic device** (backboard, halo, use of pins in traction, etc.), requiring special handling during transport

☐ Patient requires **airway** monitoring or suctioning

☐ Portable **ventilator** required

☐ Trained personnel required for administering and/or regulating **oxygen** en route

Please list an **Medical HX/DX**, which can help substantiate the above conditions: _____

_____

_____

_____

Physician Certification/Authorization: I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.

Print Physician's Name/Title: _____

Physician *(only)* Signature: _____ **Date Signed:** _____