MEDICARE

Physician Certification Statement (PCS) For Ambulance Transportation

Section I – Patient Information

Name _____ Date(s) of Service ___-___-____ to ___-___-____
Last First

Patient transported from: _____

Patient transported to: _____

Section II – Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated.

Supporting documentation for any boxes checked must be maintained in the patient's medical records.

CHECK ALL THAT APPLY

- ☐ Bed Confined ***All three below must be met to qualify for bed confinement***
  Unable to ambulate*
  Unable to get out of bed without assistance*
  Unable to safely sit up in a wheelchair*
  - o Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning.
  - o Unable to sit in chair or wheelchair due to grade II or greater Decubitus ulcer on buttocks.
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medications/fluids required during transport
- ☐ Cardiac/Hemodynamic monitoring required during transport
- ☐ Special Handling En route – (e.g. Isolation, Poor Skin Integrity)
- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Moderate to severe pain on movement
- ☐ DVT requires elevation of a lower extremity
- ☐ Morbid Obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit
- ☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others – medical supervision required
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Danger to self or others – seclusion (flight risk)
- ☐ Confused, combative, lethargic, comatose
- ☐ Inter-Facility Transport – Patient transported for higher level or specialized care not available at sending facility
  - o List reason(s) for transfer or care not available at sending facility: _____
    _____

Section III – Physician/Nurse Authorization**

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

_____ _____ _____
Signature of attending Physician, RN or Higher** Date Print Name of Person Signing

Authorizations must be completed and signed by the attending physician for schedule repetitive transports (e.g. KDU patients).
**For *unscheduled or scheduled non-repetitive transports* authorization may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practitioner, registered nurse or discharge planner (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.

For billing questions call Kanawha Co. Ambulance Pt Accts at 304-345-2312, ext. 505 or fax 304-352-5316

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