

PCS Practitioner Certification for Ambulance Transportation

FOR MEDICARE INSURANCE BENEFICIARIES

SECTION I – PATIENT INFORMATION

Name: (Last, First) _____ DOB: _____

Date(s) of Service ____ / ____ / ____ to ____ / ____ / ____

Patient Transported From: _____

Patient Transported To: _____

SECTION II – QUALIFYING DOCUMENTATION

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

- | | |
|--|---|
| <input type="checkbox"/> Bed Confined
(All three below must be met to qualify for bed confinement.) <ol style="list-style-type: none">1. Unable to ambulate, and2. Unable to get out of bed without assistance, and3. Unable to safely sit up in a wheelchair due to one of the following:<ul style="list-style-type: none"><input type="checkbox"/> Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning.<input type="checkbox"/> Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks. | <input type="checkbox"/> Non-healed fractures |
| <input type="checkbox"/> Confused, combative, lethargic, comatose | <input type="checkbox"/> Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit |
| <input type="checkbox"/> Moderate to severe pain on movement | <input type="checkbox"/> Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route |
| <input type="checkbox"/> Severe muscular weakness and de-conditioned state precludes any significant physical activity | <input type="checkbox"/> Cardiac/Hemodynamic monitoring required during transport |
| <input type="checkbox"/> Contractures | <input type="checkbox"/> I.V. medications/fluids required during transport |
| | <input type="checkbox"/> Danger to self or others – monitoring |
| | <input type="checkbox"/> Danger to self or others – seclusion (flight risk) |
| | <input type="checkbox"/> Restraints (physical or chemical) anticipated or used during transport |
| | <input type="checkbox"/> Special Handling en route – Isolation |
| | <input type="checkbox"/> DVT requires elevation of a lower extremity |
| | <input type="checkbox"/> Morbid Obesity requires additional personnel/equipment to handle |
| | <input type="checkbox"/> Risk of falling off wheelchair or stretcher while in motion (not related to obesity) |

SECTION III – PRACTITIONER'S AUTHORIZATION

For unscheduled or scheduled non-repetitive transports this authorization may be signed by:

- | | |
|---------------------------|---|
| Attending Physician | Nurse Practitioner |
| Physician Assistant | Registered Nurse or Discharge Planner (employed by the facility where the beneficiary is being treated) who has |
| Clinical Nurse Specialist | personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished. |

For scheduled repetitive transports this authorization must be signed by:

Attending Physician only

Practitioner's Name: (please print) _____ Discharge Planner

Practitioner's Signature: _____ Date: _____

I certify that the above information represents an accurate assessment of the patient's medical condition(s) and that in my professional medical opinion, this patient requires transport by an ambulance and should not be transported by any other means. I understand that this information will be used by the Health Care Financing Administration to support the determination of medical necessity for ambulance service.

Medicare requires via 42 CFR Part 410.40(d) that ambulance providers obtain a Certificate of Medical Necessity signed by the patient's physician for the provision of non-emergency ambulance transportation. This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance provider to determine if Medical Necessity has been met. Please have the ordering physician complete all sections and sign this form.

Per HCFA-Pub. 60B If the ambulance supplier is unable to obtain the signed certification statement from the attending physician, a signed certification statement must be obtained from either the PA, NP, CNS, RN, or discharge planner who is employed by the hospital or 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 furnished.

Please fax this completed form to (513) 576-9457