COMMUNITY EMS
EMERGENCY MEDICAL SERVICE

Dispatch 800-233-2367
Fax 248-415-0767

AMBULANCE TRANSPORTATION
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 and Medicaid (CMS) on all scheduled and unscheduled non-emergency transports. (Please see below for signature requirements)

***Sections 1 - 4 MUST be completed in order for the form to be compliant with state and federal billing regulations.**

Section 1

PATIENT NAME:	**DOB:**	**MEDICARE/MEDICAID ID:**
TRANSPORTED FROM:	**TRANSPORTED TO:**	**ROUND TRIP?** ☐ YES ☐ NO
TYPE OF TRANSPORT: ☐ ALS ☐ BLS	**FREQUENCY OF TRANSPORT:**	**TYPE OF ONGOING TREATMENT:**
DATE(s) OF SERVICE:	**ORDERING PHYSICIAN'S PRINTED NAME:**	**ORDERING PHYSICIAN'S NPI:**

Section 2

PLEASE PROVIDE DOCUMENTATION OF THE PATIENT'S MEDICAL CONDITION AT THE TIME OF TRANSPORT TO SUBSTANTIATE AMBULANCE MEDICAL NECESSITY.

☐ Paralysis: Hemi _____ Quad _____ Para _____
☐ Unstable fractures
☐ Contractures: Upper _____ Lower _____ Both _____
☐ DVT requires elevation of a lower extremity
☐ Moderate/severe pain on movement
☐ Restraints (physical or chemical) anticipated or used during transport
☐ Dementia ☐ Intermittent Confusion ☐ Persistent Confusion
☐ Patient is confused, combative, lethargic, or comatose.
☐ IV meds/fluids required: _____
☐ Ventilator Required
☐ Cardiac/hemodynamic monitoring required enroute
☐ Chest Tube
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling
☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Assistance/attendant required to apply, administer or regulate **oxygen** enroute

Other: _____

Common ED Reasons:

☐ **Higher Level of Care**: *(list the reason)*
- ☐ Chest Pain
- ☐ Acute MI
- ☐ ICB
- ☐ Stroke
- ☐ Multiple trauma,(list injuries): _____

☐ **Specialty Care:** *(list the reason)*
- ☐ Danger to self or others
- ☐ Psychiatric Dx: _____
- ☐ Elopement Precautions
- ☐ Peds: _____

☐ Other: _____

Section 3

All three criteria below must be met to qualify for "bed confinement".

1. Is the patient unable to ambulate? ☐ YES ☐ NO
2. Is the patient unable to get out of bed without assistance? ☐ YES ☐ NO
3. Is the patient unable to safely sit up in a wheelchair? ☐ YES ☐ NO *if YES, complete 3-A. & 3-B.

☐ a. Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning.

☐ b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers.
buttocks _____ coccyx _____ hip _____ other _____

Is the patient bed confined? ☐ **Yes** ☐ **No**
Please check or list the condition resulting in bed confinement above in section 2.

Section 4

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.

Printed Name W/Credentials:			
Title:	☐ Attending Physician ☐ Nurse Practitioner	☐ Physician Assistant ☐ Registered Nurse	☐ Clinical Nurse Specialist ☐ Discharge Planner
Authorized Signature:		**Date Signed:**	

Medicare and Medicaid regulations state that only a Physician, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse, or discharge planner may sign the physician certification statement form.