Patient Transport Services

PATIENT TRANSPORT SERVICES
420 Wards Corner Road, Suite B, Loveland, Ohio 45140
(513) 831-5999 • KY (859) 371-5999

PCS Practitioner Certification for Ambulance Transportation

FOR MEDICARE INSURANCE BENEFICIARIES

SECTION I – PATIENT INFORMATION

Name: (Last, First) ____

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

☐ Bed Confined

(All three below must be met to qualify for bed confinement)

1. Unable to ambulate, and
2. Unable to get out of bed without assistance, and
3. Unable to safely sit up in a wheelchair due to one of the following:

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

   ☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcer on buttocks

☐ Confused, combative, lethargic, comatose

☐ Moderate to severe pain on movement

☐ Severe muscular weakness and de-conditioned state precludes Any significant physical activity

☐ Contractures

☐ Intubated

☐ Vent Dependent

☐ CPAP/BiPAP Treatment during transport

☐ Non-healed fractures

☐ Orthopedic devise (backboard, halo, use of pins in traction, etc.) requiring special handling in transit

☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route

☐ Cardiac/Hemodynamic monitoring required during transport

☐ I.V. medications/fluids required during transport

☐ Danger to self or others – monitoring

☐ Danger to self or others – seclusion (flight risk)

☐ Restraints (physical or chemical) anticipated or used during transport

☐ Special Handling en route – Isolation

☐ DVT requires elevation of a lower extremity

☐ Morbid Obesity requires additional personnel/equipment to handle

☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)

☐ Other ____

____

SECTION III – PRACTITIONER'S AUTHORIZATION

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

- 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 **scheduled repetitive transports** this authorization may be signed by:

- Attending Physician only

Practitioner's Name: *(please print)* ______________________________ **Title:** ______________________

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) 576-7197