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**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 - 3 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
	DATE(s) OF SERVICE:	ORDERING PHYSICIAN'S PRINTED NAME:			ORDERING PHYSICIAN'S NPI:

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

Section 2	<u>All three criteria below must be met to qualify for "bed confinement".</u>	
	1. Unable to ambulate. <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Unable to get out of bed without assistance. <input type="checkbox"/> YES <input type="checkbox"/> NO 3. Unable to safely sit up in a wheelchair: <input type="checkbox"/> YES <input type="checkbox"/> NO *if YES, complete 3-A. & 3-B.	<input type="checkbox"/> 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. <input type="checkbox"/> b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers. buttocks _____ coccyx _____ hip _____ other _____
**Under Medicare/Medicaid regulations, diagnosis of bed confinement by itself does not substantiate medical necessity		

Please list any **Medical Hx / Dx**, which substantiates transportation by ambulance, is medically required: _____

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.

Section 3	Authorized Healthcare Provider Completing The Form On Behalf Of The Ordering Physician:			
	Title:	<input type="checkbox"/> Attending Physician <input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Physician Assistant <input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Clinical Nurse Specialist <input type="checkbox"/> 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.

Additional blank PCS forms may be downloaded from the Beaumont EMS website. PCS forms may also be completed online and printed for use @ www.beaumontmedicaltransportation.org