Patient Information Sticker Here (If Available)

Sawyer County Ambulance

Physician's Certification Statement (PCS)
For Non-Emergency Ambulance Services

Section 1 – Beneficiary Information

Patient Name:_____ Date of Transport:_____/____/_____

Transported From:_____ Transported To:_____

Section 2 – Medical Necessity Information for Non-Emergency Transportation

A. Can the patient be safely transported by car, taxi, bus, or a wheelchair van? ☐Yes ☐No
If yes, the patient does not meet the criteria for ambulance transportation.
B. Please describe the reason(s) why the patient requires monitoring and/or transport by ambulance_____

C. Is the beneficiary able to get up from bed without assistance? ☐Yes ☐No
D. Is the beneficiary able to ambulate? ☐Yes ☐No
E. Is the beneficiary able to sit in a chair or wheelchair? ☐Yes ☐No
If the answer is "no" for C, D, or E, please describe why: _____

Section 3 – For Inter-facility Transfer

A. Is the patient being transferred to a higher level of care? ☐Yes ☐No
B. Please list/describe facilities or procedures required/available at destination facility not available at originating facility?_____

C. Is the patient being discharged from the originating facility? ☐Yes ☐No Is patient an: ☐Inpatient ☐Outpatient
D. Is the patient being transported to the closest appropriate facility? ☐Yes ☐No
If no, describe why the patient has to be transported to the further facility._____

Section 4 – Additional Reasons for Ambulance Transport - Complete all that are applicable to this patient

A. Is the patient: (check all that apply)
☐Critically Injured ☐ Critically Ill ☐ Unstable
☐ In Need of Immediate Intervention

B. Needs immobilization due to recent fracture or potential fracture:
☐ Hip ☐ Leg ☐ Spine
☐ Other _____

C. Contractures: ☐ Upper Ext ☐ Lower Ext ☐ Fetal
Paralysis: ☐ Para ☐Quad ☐ Hemi

D. Decubitus Ulcers: Size: _____ Stage: _____
☐Buttocks ☐ Coccyx ☐ Hip
☐ Other _____

E. Severe Pain – Pain Scale (1-10): _____
Explain: _____

F. Requires isolation precautions (VRE, MRSA, etc.)? ☐Yes ☐No
If yes, why? _____

G. Mental Status… Is this condition:
☐ New Onset ☐ Normal Status ☐ Status Change
Does the patient exhibit: ☐Hostility ☐Violent/Combative
☐ Agitation ☐ Delirium ☐Non Compliant
Is the altered mental status the result of sedation? ☐Yes ☐No
Type:_____

H. Patient's level of consciousness precludes other means of transport?
☐Yes ☐No If yes, why? _____

I. Decreased level of consciousness:
☐Unconscious ☐Syncope ☐Unresponsive 0Incoherent
☐Lethargic ☐Semi-conscious, stuporous ☐Seizure prone
☐Intermittent consciousness ☐Hallucinating

J. Restraints required; Type: _____
Reason for restraint: ☐To prevent injury to self or others
☐Flight risk ☐To maintain upright position safely

K. Patient is too weak to travel by other means?
☐Yes ☐No If yes, why? _____

L. Requires continuous oxygen & monitoring by trained staff?
☐Yes ☐No If yes, why? _____

M. Requires airway monitoring or suctioning? ☐Yes ☐No
N. Patient is ventilator dependent? ☐Yes ☐No
O. Patient requires continuous IV therapy? ☐Yes ☐No
P. Patient requires cardiac monitoring? ☐Yes ☐No
Q. Patient is hemodynamically unstable? ☐Yes ☐No
Explain: _____

Other medical condition(s) that support the medical necessity of ambulance transportation: _____

Section 5 - Signature of Physician or Healthcare Professional

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked,** I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows: _____

_____ _____
Signature of Physician* or Healthcare Professional Date Signed

_____ _____
Printed signature NPI #

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)*

☐Physician Assistant ☐Clinical Nurse Specialist ☐Registered Nurse ☐Nurse Practitioner ☐Discharge Planner