❑ **C.J. Spellman Ambulance Service, Inc.** ❑ **Trans-Med Ambulance, Inc.**

# Physician's Certification Statement (PCS)
# Return Fax: 570-287-3384

Patient Name: _____Medicare Number: _____

Patient DOB: _____Date of Service: _____(PCS is valid for only 60 days from this date for repetitive transports)

Origin: _____Destination_____

Is the patient stay covered under Medicare Part A (PPS/DRG?) ❑Yes ❑ No

If hospital-hospital transfers, describe services needed and available only a 2nd facility_____

**Medical Necessity:** Ambulance transportation is medically necessary only if other means of transportation are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated, by the patient's condition. **Bed Confined:** is defined as 1) unable to get up from bed without assistance, 2) the beneficiary is unable to ambulate, and 3) the beneficiary is unable to sit in a chair or wheelchair. The patient must satisfy all three of the conditions.

**Check the reason(s) why a transport by ambulance is required. (Must be completed by the medical professional signing below)**

❑ The patient is "bed-confined" based on the definition listed in the box above, due to conditions indicated in the narrative below:

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❑ Advanced Dementia, late stage Alzheimer's, severe altered mental status, decreased level of consciousness.

❑ Frail, debilitated, extreme muscle atrophy, risk of falling out of wheelchair while in motion.

❑ Requires Administration of oxygen unable to self administer. Liters per minute (LPM):_____

❑ Requires airway monitoring during transport.

❑ Patient requires ❑ EKG monitoring or ❑IV infusion, during transport.

❑ Comatose and requires trained personnel to monitor condition during transport.

❑ Seizure prone and requires trained personnel to monitor condition during transport.

❑ Medicated and needs trained personnel to monitor condition during transport.

❑ Danger to self and/or others: may require restraint. ❑ Chemical ❑Physical ❑Flight Risk.

❑ Suffers from paralysis or contractures. ❑Upper Extremities, ❑Lower extremities,❑ Fetal.

❑ Unable to sit for transport without severe pain, risk to recent orthopedic surgery or unset/non healed fractures.

❑ Has decubitus ulcers Stage_____, Size___, and requires wound precautions. Wound Location_____.

❑ Requires isolation precautions /infection control precautions or other special handling during transport.

❑ Other (Must completely and thoroughly explain patient's condition at time of transport to meet medical necessity).

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I certify that the above information is true and correct based upon my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I under understand that this information will be used by the Center for Medicare and Medicaid Services (CMS) to support documentation of medical necessity and I represent that I have personal knowledge of the patient's condition at the time of transport.

_____ _____ _____

**Printed Name** **Signature** **Date**

**Circle One:** MD, DO, PA-C, APRN, RN CNS, Discharge Planner

***Only a Physician can sign for repetitive transports and the PCS only covers a 60 day range from date signed.***