Physician's Certification Statement (PCS)

Non-Emergency Ambulance Transportation

Ambulance Service of Manchester, LLC
PO Box 300, Manchester, CT 06045-0300
Phone: (860) 647-9798 Fax: (860) 643-0759

Patient Name: _____ Medicare #: _____

Patient DOB: _____ Date of Service: _____

Check ALL applicable reason(s) why a transport by ambulance is required:

Physical and Mobility Issues

- ☐ The patient is "bed-confined" under CMS guidelines due to the fact that they are unable to get up from bed without assistance AND unable to ambulate AND unable to sit in a chair or wheelchair.
- ☐ Frail, debilitated, extreme muscle atrophy AND therefore at risk of falling out of wheelchair while in motion.
- ☐ Suffers from contractures. Upper extremities ___, Lower extremities ___, Fetal ____.
- ☐ Suffers from paralysis. Hemiplegia ___, Quadriplegia ___, Paraplegia ___.
- ☐ Becomes hemodynamically unstable suddenly, orthostatic hypotension.
- ☐ Unable to sit for transport without risk to recent orthopedic surgery.
- ☐ Recent lower limb amputee. Date of amputation: ____--____--____
- ☐ Must remain immobile because of an unset or non-healed fracture of the _____.
- ☐ DVT requires elevation of a lower extremity.
- ☐ Moderate to severe pain on movement.
- ☐ Orthopedic device (backboard, halo, pins in traction, etc.) requiring special handling during transport.
- ☐ Morbid obesity effecting ability to safely travel in a wheelchair ____ lbs or ____ kgs

Mental Status Issues

- ☐ Pt requires 1:1 supervision due to: advanced dementia__, late stage Alzheimer's__, significant altered mental status__, decreased level of consciousness___. GCS: _____
- ☐ Comatose or vegetative and requires trained personnel to monitor condition during transport.
- ☐ Requires supervision during transport (check all that apply):
  - ___ Danger to self and/or others,
  - ___ Aggressive or unpredictable behavior.
  - ___ May require restraint. Chemical __, Physical __, Verbal __.
  - ___ Flight risk.

Medical Issues

- ☐ Requires assistance in the administration of oxygen. Liters per minute (LPM):_____
- ☐ Pt requires (____ EKG monitoring) or (_____ IV infusion or maintenance) during transport.
- ☐ Requires wound care precautions such as care and positioning:
  - ___ Decubitus or stasis ulcers (Stage ____, Size _____).
  - ___ Wound vac applied
  - ___ Wound location: Buttocks ___, Coccyx ___, Sacral ___, Back ___, Hip ___, Other _____
- ☐ Recent and/or residual CVA or other neurological deficit effecting ability to safely sit upright.
- ☐ Actively seizure prone and requires trained personnel to monitor condition during transport.
- ☐ Requires isolation precautions /special handling during transport for VRE, C-Diff, MRSA sputum/wound etc.
- ☐ Medicated or sedated and needs trained personnel to monitor condition during transport.
- ☐ Requires airway monitoring and/or suctioning during transport.

☐ None of the above criteria pertain and the patient is a candidate for wheelchair van, if available.

In my professional medical opinion, unless otherwise stated, this patient requires transport by ambulance and should not be transported by other means. I certify that the above information is true and correct based upon my evaluation of this patient, to the best of my knowledge and professional training. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

_____ _____ _____

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

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

ONLY AN MD CAN SIGN FOR REPETITIVE TRANSPORTS SUCH AS DIALYSIS