PHYSICIAN CERTIFICATION STATEMENT (PCS)

The section below must be completed by the patient's attending physician or authorized designee. TECHS Personnel may not complete this section.

Transport Date:

Transport From: Transport to:

Patient Name: DOB: HIC/Medicare

MARK **ALL** REASONS WHY THE PATIENT REQUIRES **NON-EMERGENCY** AMBULANCE SERVICES.

- ❑ Patient unable to sit safely in a wheelchair while vehicle in motion due to:
- ❑ Patient requires monitoring/treatment during transport: (check all applicable items below)
  - ❑ **IV** medication required in route
  - ❑ **Ventilator** dependent
  - ❑ **ECG** monitoring required in route
  - ❑ **Oxygen assistance** required in route
  - ❑ **Suctioning/airway control** required in route
- ❑ Psychiatric Hold Requires Restraints Flight Risk
- ❑ Isolation Precautions due to:
- ❑ **Special Positioning or Handling required** preventing transport by wheelchair or other means (describe positioning or handling necessary):

HOSPITAL TO HOSPITAL ONLY

What special services/treatments were needed and not available at the sending facility?

I certify I am familiar with the patient's condition ana have determined the patient's condition and have determined the patients' medical record supports ambulance transportation for the reason(s) specified above. Ambulance service is hereby ordered **(for repetitive patients, only a physician may sign)**. **Please check one:**

( )Physician ( )RN ( )Discharge Planner ( )NP ( )PA ( )CNP

Printed name: Signature: Date:

Physician Certification Statement Pursuant to CFR [Section 410, 40 (d) (2-3)]

Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is contraindicated by the patient's condition. The Centers for Medicaid Services requires documentation of the medical necessity for such services.