Greene Emergency Squad, Inc.

PCS FORM

30 Birdsall Street, Greene NY, 13778 **Phone:** 607-656-5688 **Fax:** 607-656-5677 www.greeneems.com

Physician Certification Statement of Medical Necessity for Non-Repetitive Ambulance Transport

Patient Name	Date of Birth	Last 4 of Social

Transport Date	Sending Facility	Destination

What services are needed at the destination facility that aren't available at the sending facility?		
Is the destination the closest, appropriate facility?	o Yes	If no, why?
Hospice Patients: Is this transport related to their terminal illness?	o Yes	If no, why?

Medicare Part B will only reimburse for ambulance transport if it is "medically necessary," which requires the patient to meet either of the two following criteria:

1. The patient must be "Bed Confined"
2. Transport by means other than ambulance is "Contraindicated by the Patient's Condition."

To be considered "bed confined," the patient must meet **ALL THREE** of the following criteria:	1. Unable to get up from bed without assistance 2. Unable to ambulate 3. Unable to sit in a chair or wheelchair.

Does the patient meet **ALL THREE** of these criteria to be considered bed confined?	o Yes	o No

If no, please select the patient's condition that contraindicates transport by other methods and requires transport by an ambulance at this time. **These questions must be answered by the healthcare professional signing below for this form to be valid.**

o Confusion	o Danger to Themselves/Others	o Needs cardiac or hemodynamic monitoring.
o Combative	o Needs/May Need Restraints	o Unable to tolerate a seated position for transport
o Comatose	o Non-healed fractures	o Elevation of a lower extremity due to a DVT.
o Contractures	o Medical attendant required	o Oxygen they are unable to self-administer.
o Special handling: isolation/infection control precautions		o Moderate/Severe Pain with Movement
o IV medications or IV fluids administration		o Unable to sit in wheelchair due to ulcers or wounds.
o Morbid obesity requires additional personnel/equipment		o Special handling of an orthopedic device
o Other physical and/or mental reasons: _____		

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 C.F.R. §410.40(e)(1) are met, requiring that this patient be transported by ambulance. 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. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all the Medicare regulations and applicable State Licensure laws for the credential indicated.

_____ If initialed here, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form 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 C.F.R. §424.36(b)(4). In accordance with 42 C.F.R. §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the form is as follows:

_____

Signature of Physician* or Authorized Healthcare Professional	Printed Name & Credentials	Date

*If unable to obtain the signature of the attending physician, any of the following may sign.

Physician Assistant	Nurse Practitioner	Clinical Nurse Specialist	Registered Nurse
Licensed Practical Nurse	Social Worker	Case Manager	Discharge Planner