PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY STATEMENT (PCS)

SECTION I – GENERAL INFORMATION
A. Patient Name: ____________________________ DOB: __/__/____
B. Transport from: ___________________________ Transport to: _________________________
C. Transport Date: ____________________________
D. Attending Physician: _______________________

SECTION II – MEDICAL NECESSITY
A. MEDICAL CONDITION/DIAGNOSIS that requires Ambulance transport: ________________________
B. BED CONFINED? YES NO (CMS Definition: Inability to get up from bed without assistance, ambulate, and sit in a chair including wheelchair. (Must meet all criteria)
C. PLEASE CHECK ALL THAT APPLY:

☐ Airway Compromise - Suction ☐ Isolation Precautions ☐ Paralysis (hemi, semi, quad)
☐ Cardiac Monitoring ☐ IV Maintenance ☐ Psychiatric care
☐ Comatose ☐ Moderate/severe pain on movement ☐ Restraints
☐ Confusion ☐ Morbid Obesity ☐ Should not stand/pivot/ambulate
☐ Contractures ☐ Non-healed fractures ☐ Vent Dependent
☐ Danger to self/others ☐ Oxygen & Monitoring by trained staff
☐ Unable to sit in a wheelchair due to decubitus ulcers or other wounds
☐ Unable to tolerate a seated position during transport
☐ Other: (specify) ____________________________

D. What services are required at receiving facility that CANNOT be provided at the sending facility?
_____________________________________________________________________________________

E. Closest facility? YES NO If NO, why is transport to more distant facility required?
_____________________________________________________________________________________

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL
In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient’s condition is such that transport by medically trained personnel is required. I certify that the above information will be used by the Centers of Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services.

PRINT Name: ____________________________ Credential: ____________________________
SIGN Name: ____________________________ Date Signed: ____________________________

Who Can Sign a PCS:
BCBS Patients: Physician, Physician Assistant, Registered Nurse, Discharge Planner, or Nurse Practitioner
Medicare & Medicaid: Physician, Physician Assistant, Registered Nurse, Discharge Planner, or Nurse Practitioner

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