*DMCare Express*
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# AMBULANCE TRANSPORTATION
# PHYSICIAN CERTIFICATION STATEMENT FOR MEDICAL NECESSITY

**A Physician Certification Statement (PCS) is required, pursuant to 42 C.F.R. 410.40(d) (2) and (3), by the Centers for Medicare and Medicaid (CMS) on all scheduled and unscheduled non-emergency transports. (Please see below for signature requirements)**

Section 1

***Sections 1 - 3 MUST be completed in order for the form to be compliant with state and federal billing regulations.**

| | | |
|---|---|---|
| **PATIENT NAME:** | **DOB:** | **MEDICARE/MEDICAID ID:** |
| **TRANSPORTED FROM:** | **TRANSPORTED TO:** | **ROUND TRIP?** ☐ YES ☐ NO |
| **TYPE OF TRANSPORT:** ☐ ALS ☐ BLS | **FREQUENCY OF TRANSPORT:** | **TYPE OF ONGOING TREATMENT:** |
| **DATE(s) OF SERVICE:** | **ORDERING PHYSICIAN'S PRINTED NAME:** | **ORDERING PHYSICIAN'S NPI:** |

Section 2

**PLEASE PROVIDE DOCUMENTATION OF THE PATIENT'S MEDICAL CONDITION AT THE TIME OF TRANSPORT TO SUBSTANTIATE AMBULANCE MEDICAL NECESSITY.**

All three criteria below must be met to qualify for **"bed confinement"**.

1. Unable to ambulate. ☐ YES ☐ NO
2. Unable to get out of bed without assistance. ☐ YES ☐ NO
3. Unable to safely sit up in a wheelchair: ☐ YES ☐ NO *if YES, complete 3-A. & 3-B.

☐ a. Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning.

☐ b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers. buttocks ____ coccyx ____ hip ____ other ____

****Under Medicare/Medicaid regulations, diagnosis of bed confinement by itself does not substantiate medical necessity**

Please list any **Medical Hx / Dx**, which substantiates transportation by ambulance, is medically required: _____

_____

_____

_____

_____

_____

Section 3

**Physician Certification / Authorization: I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.**

| | | | |
|---|---|---|---|
| **Authorized Healthcare Provider Completing The Form On Behalf Of The Ordering Physician:** | | | |
| **Title:** | ☐ Attending Physician | ☐ Physician Assistant | ☐ Clinical Nurse Specialist |
| | ☐ Nurse Practitioner | ☐ Registered Nurse | ☐ Discharge Planner |
| **Authorized Signature:** | | **Date Signed:** | |

**Medicare and Medicaid regulations state that only a Physician, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Registered Nurse, or discharge planner may sign the physician certification statement form.**

**Additional blank PCS forms may be downloaded from the DMCare Express website. PCS forms may also be completed online and printed for use @** *www.dmcareexpress.org*