

AMBULANCE PCS

Physician Certification Statement for Ambulance Transportation

Section 1 - Beneficiary Information

Patient Name:	Diagnosis:
Date of Transport:	Medicare/Medicaid #:
Pickup:	Destination:

Section 2 - Medical Necessity Information for non emergency transportation.

Can the patient be transported by car, taxi, bus or a wheelchair van? Yes No **If yes, the patient does not meet the criteria for stretcher transportation.**

Please describe the reason(s) why the patient required monitoring and/or transport by stretcher.

1. Is the beneficiary able to get up from bed without assistance? Yes No
 2. Is the beneficiary able to ambulate? Yes No
 3. Is the beneficiary able to sit in a chair or wheelchair? Yes No

Section 3 - For Hospital to Hospital Transfers Only

Is the patient being transferred to a higher level of care? Yes No

(A) Please list/describe facilities or procedures required/available at destination facility not available at originating facility _____

(B) Was the patient discharged at originating facility either as an inpatient or outpatient? Yes No

(C) Was the patient transported to the closest appropriate facility? Yes No **If no, describe why the patient had to be transported to the further facility, please notify patient/family that they may be financially responsible for the difference in mileage.**

(D) If air ambulance is required, please describe why the patient needs **air vs. ground** ambulance.

Section 4

Print the name of the physician ordering ambulance transportation: _____ **UPIN:** _____

Signature: _____ **Date:** _____

Physician RN Discharge Planner Nurse Practitioner PA Clinical Nurse Specialist

I certify that the above information represents an accurate assessment of the patient's medical condition(s) and that in my professional medical opinion, this patient requires transport by an ambulance and should not be transported by any other means. I understand that this information will be used by CMS to support the determination of medical necessity.