AMBULANCE PCS

Physician Certification Statement for Ambulance Transportation

1.800.328.1377 – Emergency Dispatch
612.378.5465 - Phone
612.638.4970 – Fax

Section 1 – Beneficiary Information

Patient Name		Diagnosis	
Date of Transport		Medicare / Medicaid #	
Sending Facility		Destination	

Section 2 – Hospital to Hospital Transfers

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

List the facilities required/available at destination facility not available at the originating facility

☐ Burn Care ☐ Trauma Care ☐ Cardiac Care ☐ Critical Care ☐ Pediatric Care ☐ Other____________________

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.

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Please notify the patient/family that they may be financially responsible for the difference in mileage.

Section 3 – Air Ambulance Transportation

Please select below the condition(s) requiring transportation by air ambulance

☐ Intracranial bleeding requiring neurosurgical intervention	☐ Cardiogenic Shock
☐ Burns requiring treatment in a burn center	☐ Conditions requiring treatment in a Hyperbaric Oxygen Unit
☐ Multiple Severe Injuries	☐ Life Threatening Trauma

☐ Other (please explain)

☐ Patient has a medical condition that requires immediate and rapid transport due to the nature and/or severity of their illness / injury, and transportation by ground ambulance in excess of 30 minutes would endanger the patient's life or health

Section 4 – Physician Certification

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

Signature of Physician or Healthcare Professional*	*Date*	*Print Name and Credentials (MD, RN, etc.)*

** This form may be signed by any of the following if the attending physician is unavailable to sign (please check the appropriate box below)*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner