24-Hour Dispatch
716-626-4100

Dispatch FAX
716-626-3606

PHYSICIAN CERTIFICATION STATEMENT (PCS)

FOR AIR AND GROUND AMBULANCE TRANSPORT

BENEFICIARY INFORMATION

PLACE PATIENT STICKER HERE

Date of Transport	
Sending Facility	
Destination	
Diagnosis	

MEDICAL NECESSITY INFORMATION

*****NOTE:** LACK OF ALTERNATIVE TRANSPORTATION SERVICES **DOES NOT** CREATE A MEDICAL NECESSITY FOR **AMBULANCE** SERVICES.

Describe the **PHYSICAL** or **MENTAL CONDITION** *(not diagnosis)* of the patient **AT THE TIME OF AMBULANCE TRANSPORTATION** that requires the patient to be transported on a stretcher in an ambulance and why transport by other means in contraindicated by the patient's condition.

Can the patient be transported by car, taxi, bus, stretcher van or wheelchair van?	☐ Yes ☐ No
If YES, this patient does not meet criteria for ambulance transportation.	
Is this patient bed confined? To be considered as "bed confined," the patient must be unable to get up from bed without assistance; AND unable to ambulate; AND unable to sit up in a chair or wheelchair.	☐ Yes ☐ No

In addition to completing the above questions, please check any of the following conditions that apply:

☐ Contractures ☐ Ventilator dependent ☐ IV meds/fluids required
☐ Danger to self/others ☐ Patient is combative ☐ Requires restraints to prevent harm and/or injury
☐ Requires isolation precautions (MRSA, VRE, etc.) ☐ Paralyzed: ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia
☐ Overall wasting and too weak to sit up in wheelchair ☐ Requires seizure precautions and monitoring
☐ Requires airway monitoring or suctioning ☐ Requires continuous oxygen-unable to self-administer
☐ Cardiac monitoring required during transport ☐ Hemodynamic monitoring required during transport
☐ Moderate/Severe Pain on movement ☐ Unable to sit in wheelchair due to decubitus ulcers or other wounds
☐ Morbid obesity requiring additional personnel/equipment to safely handle patient
☐ Patient has decreased level of consciousness ☐ confused ☐ lethargic ☐ comatose
☐ Patient has non-healed fractures of: ☐ cervical spine ☐ thoracic spine ☐ lumbar spine ☐ sacrum/coccyx ☐ pelvis/hip ☐ femur
☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport
☐ Other (please specify) _____

AIR AMBULANCE ONLY

☐ Intracranial bleeding requiring neurosurgical intervention ☐ Conditions requiring treatment in a Hyperbaric Oxygen Unit
☐ Burns requiring treatment at a burn center ☐ Cardiogenic Shock
☐ Multiple Severe Injuries ☐ Life Threatening Trauma
☐ Other _____
☐ Patient has a medical condition as described above that requires immediate and rapid transport due to the nature and/or severity of their illness/injury, and transport by ground ambulance in excess of 30 minutes would endanger the patient's life or health

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 that can provide the required service?	☐ Yes ☐ No
***If no, why did the patient require transport to a further facility?	

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.

Provider Name (please print)		Provider Signature	
☐ MD ☐ PA ☐ NP ☐ RN ☐ Case Manager		Date	