PHYSICIAN CERTIFICATION STATEMENT (PCS)
FOR NON-EMERGENCY AMBULANCE TRANSPORT

Transport Date:	☐ **Repetitive** ☐ **Non-Repetitive** (PCS effective for 60 days for repetitive transports or for a single prescheduled or unscheduled transport only)	**Today's Date:**

Section 1 – Patient Information

First Name	Middle Initial:	Last Name:	Date of Birth:
Social Security Number:	Medicare No.:		Part B? ☐ Yes ☐ No

Medicaid if not Emergency, please call LogistiCare for Reference (1-866-254-5409)

Diagnosis:

Section 2 – Transport Information

Transport From:

Transport To:

Reason for Transport: (include name of service, treatment, or procedure the patient needs at the receiving facility)

Is the service, treatment, or procedure for which patient being transported available at originating facility? ☐ Yes ☐ No

→	Physician Signature Only:	Date:
→	Medical Support Staff Signature Only:	Date:

Section 3 – Medical Necessity Information

NOTE: Lack of alternative transportation services DOES NOT create a medical necessity for AMBULANCE services.

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 transportation by medically trained personnel is required. The CMS definition of bed-confinement is: The inability to get up from bed without assistance; unable to ambulate; and unable to sit in a chair, including unable to sit in a wheelchair independently. (ALL MUST BE MET)

Does this patient meet CMS definition of bed confinement? ☐ Yes ☐ No

If the patient does not meet the definition but still requires ambulance, the reason must be detailed below.

Please check the appropriate medical conditions listed below which would necessitate transport by ambulance and make all other means of transport contraindicated based on patient safety and health.

This Patient (**check all that apply):**

☐	Requires IV maintenance	☐	Requires restraints or sedation
☐	Requires airway monitoring and/or suctioning	☐	Requires isolation precaution (VRE, MRSA)
☐	Is ventilator dependent	☐	Is on hip/leg/back precautions
☐	Requires cardiac EKG monitoring	☐	Comatose and requires trained monitoring
☐	Has decubitus ulcers and requires wound precautions	☐	Is exhibiting signs of decreased level of consciousness
☐	Weight limit exceeds wheelchair or gurney van safety limitations with other medical conditions		
☐	Requires other services or equipment. Please list:		