Certification of Medical Necessity (PCS)

Disclaimer: The presence of a signed certification statement does not, by itself, demonstrate that the transport was medically necessary and does not absolve the healthcare provider from meeting all other coverage and documentation criteria. You may be asked for further documentation on this patient such as medical history, progress notes, etc. The presence of a signed certification statement does not guarantee Medicare coverage, benefits, or payment. Please contact your facility Medicare Benefits or compliance officer with questions regarding the rules and regulations pertaining to covered services, destination, etc. This medical attestation will be attached electronically to the transport record for this patient and is only applicable to the dates indicated on this record.

Service Verification:

Patient Last Name _____ , First Name _____ Born _____/_____/_____ (MM/DD/Year)

Medical Procedure not available at origin: _____

Provide the full name or description of the required procedure of service, without using abbreviations.

Destination: _____

Date of transport: _____ Through _____

If authorizing a recurring transport, this form must be signed by a physician.

Authorized By: First Name: _____ Last Name: _____

Provide your full legal first and last name, no initials.

Discharge Planner (LVN etc.) ____ Nurse Practitioner (NP) _____ Physician Assistant (PA) _____

Clinical Nurse Specialist _____ Physician (M.D. o D.O.) _____ Registered Nurse (RN) _____

Medical Need (Check all that apply)

☐ Is comatose and requires monitoring.

☐ Requires airway monitoring or suctioning.

☐ Requires monitoring and elevation of a lower extremity due to DVT.

☐ Requires IV medications and/or cardiac/hemodynamic monitoring.

☐ Is a danger to self or others, has an acute loss of awareness, or requires restraints/sedation for safe transport.

☐ Is ventilator or oxygen dependent and is physically or mentally unable to self-regulate.

☐ Is seizure prone and requires monitoring.

☐ Requires isolation precautions due to: _____.

MRSA does not qualify

☐ Has an unrepaired or recent fracture or joint replacement to: ☐ Neck ☐ Spine ☐ Arm-Right ☐ Arm-Left ☐ Leg-Right ☐ Leg-Left

☐ Has a ☐ stage 3 ☐ stage 4 ☐ unstageable decubitus ulcer on the ☐ buttocks ☐ sacrum

☐ Has severe contractures of Proximal (Left Knee / Right Knee)

___ 5 degrees ___ 25 degrees ___ 45 degrees ___ 65 degrees ___ 85 degrees ___ 105 degrees ___ 125 degrees ___ 145 degrees ___ 165 degrees

___ 10 degrees ___ 30 degrees ___ 50 degrees ___ 70 degrees ___ 90 degrees ___ 110 degrees ___ 130 degrees ___ 150 degrees ___ 170 degrees

___ 15 degrees ___ 35 degrees ___ 55 degrees ___ 75 degrees ___ 95 degrees ___ 115 degrees ___ 135 degrees ___ 155 degrees ___ 175 degrees

___ 20 degrees ___ 40 degrees ___ 60 degrees ___ 80 degrees ___ 100 degrees ___ 120 degrees ___ 140 degrees ___ 160 degrees ___ 180 degrees

☐ Has been given analgesic/sedative _____ and requires continuation of care and monitoring.

Specify Medication Name and Dosage

☐ Is bed-confined, unable to get up from bed without assistance, unable to ambulate, and unable to sit in a wheelchair for any length of time:

_____

Describe the medical condition resulting in bed-confinement, ICD-9 or ICD-10 codes are acceptable if they are relevant to the claim.

☐ At the time of transport, cannot be transported by any other means without endangering the patient's health:

_____

Note: Transport by ambulance is not justified by mere fact of a physician request, or by lack of availability of other transport.

Certification: Read and confirm all three certifying statements:

☐ I certify that I have personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or delivered.

☐ I certify that the information entered into this form represents an accurate assessment of patient's medical condition.

☐ I certify that in my medical opinion, the above-named patient cannot be safely transported by any means other than an ambulance with Medically-trained.

_____ Date: _____

Sign your full legal first and last name, no initials