Time Sensitive – Urgent Response

REPETITIVE PATIENT

PHYSICIAN CERTIFICATION STATEMENT
FOR AMBULANCE TRANSPORTATION
AS REQUIRED BY MEDICARE

PATIENT NAME	MEDICARE NUMBER	MONTH OF SERVICE

No payment may be made for ambulance services where some means of transportation, other than an ambulance, could be utilized without endangering the individual's health, whether or not such other transportation is available. Medical necessity is established from patient's condition, not the diagnosis that makes the use of any other method of transportation contraindicated. The ambulance environment must offer something that would significantly improve the safety and health of the patient. For repetitive patients (ex. Dialysis patients) this form must be completed, signed, and dated by a physician. Failure to complete the required documentation may result in an interruption of service and/or may cause a financial burden to the patient.

I. AMBULANCE TRANSPORTATION IS MEDICALLY NECESSARY ___ YES _____ NO

II. AMBULANCE TRANSPORTATION IS MEDICALLY NECESSARY FOR THE FOLLOWING REASONS: (Please select all that apply)

- ☐ **Bed Confined. For Medicare purposes, this means completely confined to a bed and unable to tolerate any activity out of bed. All three of the following must apply for a patient to be considered bed confined.**
  - **Unable to get up from bed without assistance**
  - **Unable to ambulate and**
  - **Unable to sit in a chair or wheelchair**
- ☐ **Other means of transportation are contraindicated because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. Significant medical documentation must accompany these claims.**

III. Select ALL physical conditions that necessitate stretcher transport opposed to any other means:

- ☐ **Postural Instability**
- ☐ **Non Weight Bearing Condition**
- ☐ **Paralysis**
- ☐ **Paresis**
- ☐ **Decubitus**
- ☐ **Amputations**
- ☐ **Contractures**
- ☐ **Fracture/Dislocation**
- ☐ **Requires restraints to prevent falls**
- ☐ **Requires total/extensive care for ADL's**
- ☐ **Requires Respiratory/Cardiac/IV monitoring**
- ☐ **Alzheimer's/Dementia/Altered LOC or Cognition**
- ☐ **Moderate/Severe pain on movement**
- ☐ **Other: _____**

_____

Per CMS regulations at 42.CFR.410.40(d) this form is required on non-emergency transports provided to Medicare recipients who are under the direct care of a physician.

Physician Certification / Authorization: I certify that the information contained above represents an accurate assessment of the patient's medical condition.

Stamped signature and/or date may not be used to sign this PCS Form. If used this form is considered invalid.

SIGNATURE OF PHYSICIAN	PRINT PHYSICIANS NAME _____M.D.	DATE

Acadian Ambulance Service
P.O. Box 98000 LAFAYETTE, LOUISIANA 70509-8000
1-800-259-2222