PCS

Run # _____

Phone # (206) 988-5000
Fax # (425) 454-0208

(Physician's Certification Statement of Medical Necessity for Ambulance Transport)

Date of Transport: ____/____/____ Expiration Date: ____/____/____
(Repetitive transports require a physician's signature: expires a maximum of 60 days after physician's signature)

Patient's Last Name: _____
Patient's First Name:_____ MI: _____
Sex: (Circle One) M / F DOB: ___/___/___ SS#:_____
Medicare #:_____Medicaid #:_____

Calling Facility Name:	
Patient Transported To:	
Primary Diagnosis:	
Secondary Diagnosis:	

Is the beneficiary BED CONFINED at the time of Transport? → Y☐ N☐
*Bed confined is defined by Medicare as the inability to get up from bed without assistance **and** the inability to ambulate **and** the inability to sit in a chair or wheelchair.*

1. The minimum safe level of transportation was or is:
   - ☐ BLS (Any means other than a fully equipped BLS ambulance could have endangered the patient's health.)
   - ☐ Critical Care (Any means other than a fully equipped ALS ambulance with minimum 1 RN & 1 EMT could have endangered the patient's health.)
2. Did the patient require positioning attained only by bed or stretcher? → Y☐ N☐
3. Other means of transport are contraindicated based on the following conditions requiring ambulance transport:

- ☐ Requires continuous oxygen (unable to self-administer)
- ☐ Requires airway monitoring
- ☐ Patient is ventilator dependent
- ☐ Requires EKG monitoring
- ☐ Has Continuously running intravenous devices
- ☐ Requires isolation precautions (VRE, MRSA, etc.)
- ☐ Cannot safely support themselves in a wheelchair
- ☐ Requires medical supervision during transport (explain below)
- ☐ Is comatose or obtunded, requiring trained monitoring
- ☐ Has decubitus ulcers and requires wound precautions
- ☐ Unable to get out of bed safely with one person assisting
- ☐ Other

Explain/elaborate on conditions (not necessarily diagnoses) which necessitate ambulance transport:

I certify the above information represents an accurate assessment of the patient's medical condition(s). I understand the information will be used by the Health Care Finance Administration to help determine the Medical Necessity for ambulance service.

Signature	Title (Only the below listed titles can legally sign the patient's PCS)
Print Name	Date

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