STAT EMS
Where Service Meets Compassion

Physician's Certification Statement (PCS) – Used For Determining the MEDICAL NECESSITY of Ambulance Service

DISPATCH: 1 - 810 - 233 - 4400

Incident # _____ **Date of Transport** _____

****

Certification Date ***Max 60 days**: _____ / _____ / _____

Patient Name:

Contact Name & Phone Number @ Destination:

Transporting To (facility name & address):

Transporting From:

LEVEL of Care: ALS ☐ BLS ☐ SCT(*specialty*) ☐

-REQUIRED INFORMATION FOR ALL MAJOR INSURANCE PROVIDERS-

Under MEDICARE & MEDICAID 42 CFR 410.40(d) this PCS is REQUIRED for consideration for payment.
Without a completed PCS, financial responsibility for services rendered may rest on the patient or requesting facility.

Michigan **MEDICAID** Subscribers **REQUIRE a PCS** to be **SIGNED BY the PHYSICIAN REQUESTING the TRANSPORT**

SIGNATURE REQUIRED

(RN may complete; Physician's signature required for MEDICAID)

I certify that the information on the PCS is representing the patient referenced above (Patient Name), and the information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I certify I am familiar with the patient's condition. I understand that this information will be used by the Centers for MEDICAD and MEDICARE Services (CMS), and/or its agents, to support the determination of medical necessity for ambulance service(s) provided.

Physician Printed Name:

Physician/UPN Provider Number:

Authorized Signature/Verbal Order ☐:

Date Signed: _____ / _____ / _____

Patients Insurance Carrier: **(Attach FACE Sheet to PCS)**

Documents to be sent with patient: **(Pt FACE Sheet)**

- ☐ **PCS**
- ☐ Signed transfer sheet
- ☐ Petition for hospitalization (PSY consult or petition)
- ☐ Chest X-Ray
- ☐ DSS 3877/DSS 3878
- ☐ LABS
- ☐ Home discharge instructions
- ☐ Other (explain) _____

Please **CHECK ALL** appropriate/applicable medical conditions below, which would necessitate transport by ambulance according to HCFA definition of confinement. Patient's need must necessitate an ambulance, and make **ALL** other means of transportation contraindicated based on the referenced patients health and/or safety.

HCFA definition of confinement is: Unable to get from bed without assistance; unable to ambulate, sit in a wheel chair, stand or pivot while supporting body weight; unable to sit in a chair (supporting own posture), including a wheel chair.

Does the referenced patient meet any of this criteria?

☐ YES: Complete **MEDICAL NECESSITIES**, and check ALL appropriate/applicable medical conditions listed below;
NOTE: Check "Other" for conditions/requirements not listed.

Can this Pt be SAFELY transported by wheelchair van?

☐ If YES: Contact dispatch and request a wheelchair van-

MEDICAL NECESSITIES

- ☐ Pt is not wheelchair able (should be unable to safely assist themselves, unable to sit, stand, pivot or safely use a wheelchair)
  REASON: _____
- ☐ Pt is comatose or unconscious and requires monitoring
- ☐ Pt has an IV in place, and requires visual monitoring
- ☐ Requires physical restraints and/or the Pt is chemically restrained (Medication Given: _____; Time: _____)
- ☐ Pt is bed confined **and** is unable to get out of bed without assistance
  Bed confined *just* @ time of transport: WHY? _____
- ☐ MUST remain immobile due to unset FX: (FX Site: _____)
- ☐ Pt is paralyzed and bed confined, **and** is unable to get out without assistance.
- ☐ Pt requires ECG Monitoring during transport
- ☐ Pt MUST be moved to a psychiatric ward/no psychiatric ward rooms available
- ☐ Pt has extreme muscular atrophy or contractures, and is at risk of falling out of a wheel chair during van transport.
- ☐ Pt unable to control secretions, airway monitoring/suctioning may be needed
- ☐ There is NO bed available at first facility.
- ☐ Patient is ventilator dependent
- ☐ Pt requires ISOLATION PRECAUTIONS during transport
- ☐ Other (explain): _____
  _____