

**LIFEGUARD AMBULANCE SERVICE
PHYSICIAN'S CERTIFICATION STATEMENT (PCS)**

Physician's Name _____	Patient's Name _____	<u>LGTS USE ONLY</u>
Phone # _____	Medicare # _____	
Fax # _____	From _____	
	To _____	Transport Date _____
		Run # _____

1. This form must be completed in its entirety.
2. The patient's condition at the time of transport must be documented.
3. Medical Necessity criteria must be clearly documented according to CMS PCS requirements.
4. If this PCS is for a repetitive patient (identified as a patient requiring three (3) or more transports within a ten (10) day period), a physician must sign this form prior to the first transport. This form may serve for a period of sixty (60) days.

Medicare requires under 42CFR, Part 401.40(d) that ambulance providers obtain a Physician's Certification Statement (PCS), signed by a listed clinician, for the provision of non-emergency transportation. This form has been designed to assist clinicians, Medicare beneficiaries, and ambulance provider in determining if medical necessity has been met. Authorized signers please complete the medical necessity section of this form and then sign the form, listing your credential.

MEDICAL NECESSITY CRITERIA

To be completed by a clinician who is employed or contracted by the facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was being furnished.

<input type="checkbox"/> Requires continuous airway monitoring or suctioning. <input type="checkbox"/> Is comatose and requires monitoring. <input type="checkbox"/> Is seizure-prone and requires monitoring. <input type="checkbox"/> Has an unrepaired or recent fracture/joint replacement and must remain immobile. <input type="checkbox"/> Is ventilator dependent. <input type="checkbox"/> Requires continuous IV therapy. <input type="checkbox"/> Requires EKG cardiac monitoring. <input type="checkbox"/> Requires restraints and/or sedation. <input type="checkbox"/> Has severe contractures. <input type="checkbox"/> Has decubitus ulcers and requires wound precautions/special handling (define stage and location in the adjacent column). <input type="checkbox"/> Is exhibiting acute loss of awareness <input type="checkbox"/> Requires isolation precautions: VRE MRSA Other: _____ <input type="checkbox"/> Pain medication given prior to transport needs continuation of care and advanced cardiac life support (ACLS) monitoring <input type="checkbox"/> Patient requires services not available at this health care facility. Describe service: _____	<input type="checkbox"/> Patient is bed -confined <p>IF THIS BOX IS CHECKED, The section below <u>MUST</u> be completed describing why the patient is bed bound. Why is it <u>MEDICALLY</u> necessary for patient to be transported by ambulance. Narrative or ICD-9 codes are acceptable.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p align="center">LIFEGUARD USE ONLY BELOW THIS LINE</p> <p>EMT/MEDIC PRINT _____</p> <p>EMT/MEDIC SIGNATURE _____</p> <p><input type="checkbox"/> Sent to Operations Prior to Transport</p> <p><input type="checkbox"/> Facility Refused</p> <p><input type="checkbox"/> Insufficient Documentation for Transport</p>
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Clinician's Name _____	UPIN # _____
Clinician's Signature _____	Date _____

See FAX numbers on next page.



FAX NUMBERS

**Nashville, TN
ATT: Robin Winans
FAX 615-724-1048**

**Chattanooga, TN; Knoxville, TN; Dade County, GA
ATT: Kathy Chance
FAX 865-637-4800**

**Santa Rosa County, FL; Northwest FL
ATT: Carissa Haradon and/or April Downing
FAX 850-983-5374**

**Birmingham, AL; Mobile, AL
ATT: April Vining
FAX 205-324-9915**

**Houston, TX
ATT: Jasmine Freeman
FAX 205-380-2074**