

A Physician Certification Statement (PCS) is required, pursuant to 42 C.F.R. 410.40(d)(2) and (3), by the Centers for Medicare/Medicaid (CMS) on all scheduled and unscheduled non-emergency transports.

FOR REPETITIVE PATIENTS (E.G. DIALYSIS PATIENTS), THIS AUTHORIZATION MUST BE COMPLETED AND SIGNED BY A PHYSICIAN. FAILURE TO RETURN THE REQUIRED DOCUMENTATION MAY RESULT IN AN INTERRUPTION OF SERVICE AND MAY CAUSE A FINANCIAL BURDEN TO THE PATIENT.

The Physician Certification Statement is valid for 60 days from the date of the physician's signature.

PATIENT NAME: _____ DOB: _____

PICKUP LOCATION: _____

DIALYSIS FACILITY: _____ WOUND CARE FACILITY: _____

Please check the appropriate medical condition(s) listed below, if applicable, which would necessitate transport by ambulance and make all other means of transport contraindicated based on patient safety and health. **PLEASE CHECK ALL THAT APPLY.**

_____ **Bed Confined:** All three criteria below must be met to qualify for bed confinement.

1. Unable to ambulate
2. Unable to get of bed without assistance
3. Unable to safely sit up in a wheelchair
 - Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning
 - Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers
buttocks: _____ *coccyx:* _____ *hip:* _____ *other, list:* _____

_____ **Morbid Obesity:** requires additional personnel/equipment to handle

_____ Suffers from **Paralysis:** *hemi:* _____ *quad:* _____ *para:* _____

_____ Patient has **Contractures:** *upper:* _____ *lower:* _____ *both:* _____

_____ Patient has non-healed **Fractures:** Location: _____

_____ Exhibiting signs of a **decreased level of consciousness:**

confused: _____ *combative:* _____ *lethargic:* _____ *comatose:* _____

_____ **DVT** requires elevation of a lower extremity

_____ **Seizure** prone and requires trained monitoring

_____ Patient requires **Isolation Precautions**, reason: _____

_____ **Required during transport:** IV Medications _____ IV Fluids _____ Cardiac Monitoring _____ Hemodynamic Monitoring _____

_____ **Orthopedic device** (backboard, halo, use of pins in traction, etc.), requiring special handling during transport

_____ Patient requires **airway** monitoring or suctioning

_____ Portable **ventilator** required

_____ Trained personnel required for administering and/or regulating **oxygen** en route

Please list an **Medical HX/DX**, which can help substantiate the above conditions: _____

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

Print Physician's Name/Title: _____

Physician (only) Signature: _____ **Date Signed:** _____