Run #

Patient Name:

SECTION I – GENERAL INFORMATION

First Name:_____ Last Name:_____ Date of Birth:_____ Medicare#:_____

Transport Date*:_____ Repetitive Transport Expiration Date (Max 60 Days From Date Signed):_____

* This PCS is valid for all trips on the date of transport (i.e., round trips) and for scheduled/repetitive trips in the 60-day range as noted above.

Origin: _____ Destination:_____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required?_____

If hosp-hosp transfer, describe services needed at destination facility not available at origin facility:_____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe:_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. To be "bed confined" the patient must be: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined) **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the PHYSICAL OR MENTAL CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

2) Is this patient "bed confined" as defined above? ☐ Yes ☐ No

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Moderate/severe pain on movement
☐ Danger to self/others ☐ IV meds/fluids required ☐ Special handling/isolation required
☐ Patient is confused, combative, lethargic, or comatose ☐ DVT requires elevation of a lower extremity
☐ Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute
☐ Restraints (physical or chemical) anticipated or used during transport
☐ Cardiac/hemodynamic monitoring required enroute
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport
☐ Unable to maintain erect sitting position in a chair for time needed to transport
☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds on buttocks
☐ Morbid obesity requires additional personnel/equipment to safely handle patient
☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reasons documented on this form. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____

_____ _____

Signature of Physician* or Healthcare Professional Date **PRINT NAME AND CREDENTIALS (MD, RN, etc.)**

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the form may be signed by any of the following if the attending physician is unavailable to sign (please check appropriate box below)*

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