Delaware County
Emergency Medical Service

Run #
Matching #

AMBULANCE TRANSFER FORM (PCS)

Physician Certification of Medical Necessity Statement

Initial Transport Date:_____ Certification Expiration Date (Max. 60 Days):_____

(Note: A PCS form may be effective for 60 days for repetitive transports only.)

Patient Name: _____ DOB: _____

Supporting Diagnosis: _____

Transport From: _____ Transport To: _____

Attending Physician: _____

Bed Confined? **YES** or **NO** CMS Definition: *Inability to get up from bed without assistance, ambulate, and sit in a chair, including a wheelchair (must meet all criteria).*

(Check one)

PLEASE CHECK ALL THAT APPLY:

- ☐ requires continuous oxygen & monitoring by trained staff
- ☐ requires airway monitoring or suctioning
- ☐ requires cardiac monitoring or IV maintenance
- ☐ comatose and requires trained monitoring
- ☐ is seizure prone and requried trained monitoring
- ☐ is exhibiting signs of decreased level of cnsciousness
- ☐ requires restraints
- ☐ fracture of the _____
- ☐ contractures (upper, lower)
- ☐ has decubitus ulcers & requires wound precautions
- ☐ requires isolation precautions (VRE, MRSA, etc.)
- ☐ unable to be transported safely by wheelchair due to other conditions indicated on this form
- ☐ patient is ventilator dependant
- ☐ paralysis (hemi, semi, quad)
- ☐ requires psychiatric care

☐ Other reason: _____

_____

_____

TRANSFER TO ANOTHER FACILITY, CHECK ALL THAT APPLY:

- ☐ this transfer has been requested by the patient/family
- ☐ this transfer has been requested by the patient's physician
- ☐ no appropriate bed is available at our facility
- ☐ requires specialty physician not available at our facility — explain: _____
- ☐ requires special services not available at our facility — explain: _____

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required. I certify that the above information is true and correct based on my evaluation of the patient, to the best of my knowledge. I understand that this information will be used by the Centers for Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services.

(Medicaid: Only a Physician, Physician's Assistant or Nurse Practitioner may sign.)
(Select any listed for Blue Cross & Medicare)

- ☐ **Physician**
- ☐ **Physician Assistant**
- ☐ **Nurse Practitioner**
- ☐ *Registered Nurse*
- ☐ *Certified Nurse Specialist*
- ☐ *Discharge Planner*

(Note: An LPN is not authorized by Medicare to sign this form unless they are a Discharge Planner).

Print Name: _____

Sign Name: _____

Date Signed: _____/_____/_____