Physican's Certification Statement (PCS)

Port City Ambulance Service (843) 800-1112

PORT CITY AMBULANCE SERVICE LLC

Patient Sticker Area

Patient Name _____

Date of Birth _____/_____/_____

Transport Date (Start date if repetitive) _____/_____/_____

Period End Date (If repetitive) _____/_____/_____

Transport From_____ Room # _____

Transport To _____Room # _____

Medicare/Insurance ID # _____

- **This form must be completed in its entirety.**
- **In the absence of a physician, other signers as identified below may complete the document,**
- **The patient's condition at the time of transport must be documented.**
- **Medical necessity criteria must be clearly documented according to CMS requirements.**

If this PCS is for a REPETITIVE PATIENT, the PCS must be obtained in advance of the first transport from the attending physician. The PCS must be dated no earlier than 60 days in advance of the first transport. This form may serve for a period of 60 days. Medicare requires under 42 CFR, Part 410:40(d) that ambulance providers obtain a 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 providers to determine if a medical necessity is met.

Medical Necessity Criteria

The section below is to be completed by a clinician employed by the facility where the beneficiary is being treated. The clinician must have knowledge of the beneficiary's condition at the time transportation was order or service rendered

Check all Medical Necessity Criteria and Complete the Narrative

- ☐ Requires continuous oxygen, airway monitoring or suctioning
- ☐ Comatose and requires monitoring
- ☐ Seizure prone requires monitoring
- ☐ Unrepaired or unhealed fracture
- ☐ Requires continuous IV therapy
- ☐ Requires physical or chemical restraint
- ☐ ECG monitoring required
- ☐ Severe Contractures
- ☐ Decubitus ulcers and requires wound precautions and special handling

☐ Patient is bed confined before and after the transport. Patient is unable to get up from bed without assistance and unable to ambulate or sit in a wheelchair. *Describe in narrative the condition not patient to be moved by any other means.

Narrative/ Medical Necessity Explanation

_____

_____

_____

_____

_____

Level of Service (Check one)

☐ **BLS** ☐ **ALS** ☐ **SCT**

Repetitive patient (PCS good for 60 days)

Physician Phone Number_____

Clinician Name (Printed) _____

Clinician Signature _____

Title (CIRCLE ONE)

PA NP CNS RN

MD/DO Discharge Planner