Run # Matching #

HVA JCA MCA LCA ACA

Dispatch: 1-800-872-1111 Billing: 1-800-507-7847
Fax: 734-477-6786

This form is valid for 60 days from the date of physician signature

REPETITIVE PATIENT FORM

Physician Certification of Medical Necessity Statement

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

For repetitive patients (e.g., dialysis or radiation) 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.

Transport date:_____/_____/_____ Attending physician: _____

Patient name: _____ D.O.B._____/_____/_____

Transport from: _____ Transport to: _____

CHECK ALL THAT APPLY TO YOUR PATIENT:

( ) Bed confined; unable to get up from bed without assistance, unable to ambulate, unable to sit in a wheelchair.

( ) Exhibiting signs of decreased level of consciousness.

( ) Patient is ventilator dependent.

( ) Requires (Circle all that apply): airway monitoring/suctioning, IV monitoring/maintenance, cardiac EKG monitoring, seizure prone requires trained monitoring, medicated requires trained monitoring.

( ) Could only be moved by stretcher because of _____

( ) Requires oxygen during transport because of _____

( ) Unable to sit due to decubitus ulcers of the _____

( ) Require (circle all that apply); psychiatric hold, requires restraints, flight risk

( ) Unconscious or in shock.

( ) Unable to sit or hold self in place, even with seatbelts, due to paralysis or contractures of the _____

( ) Medical need for the ambulance: _____

TRANSFER TO ANOTHER FACILITY, CHECK ALL THAT APPLY:

( ) Requires specialty facility or special services not provided at our facility, explain: _____

_____

( ) Patient family/convenience request for transfer

( ) No appropriate bed available at our facility

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 this 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.

_____ _____ Date:_____/_____/_____

Printed Name / Physician Only Signature / Physician Only