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AMBULANCE TRANSFER FORM (PCS)

Physician Certification of Medical Necessity Statement

Initial Transport Date: ______________________ Is this a repetitive transport? (Max. 60 days): **Yes / No** (Circle One)

Patient Name: ____ DOB: ____________________________________

Supporting Diagnosis: ____

Transport From: ____________________________________ Transport To: ____________________________________

Attending Physician: ____

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

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 requires trained monitoring
- ☐ is exhibiting signs of decreased level of consciousness
- ☐ 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 dependent
- ☐ 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 -- explain: ____
- ☐ 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 a transportation by medically trained personnel is required. I certify that the above information is true and corrected 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.

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

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

Print Name: ____

Sign Name: ____

Date Signed: ____________/______________/________________

[Place Patient Sticker here]