Physician Certification Statement (PCS) for Non-Emergency Ambulance Transportation

FIRST RESPONSE EMS
Ambulance and Medical Services

Dispatch: 1-(833) 633-3367

A "City of Detroit" Agency

Section 1: General Information

Transport Date:_____ Certification Exp Date (max 60 days) _____

Patient Name: _____ DOB:_____

Medicare #:_____ Medicaid #: _____

Pick Up Location:_____

Drop Off Location:_____

If hospital to hospital transfer, describe reason for transfer: _____

_____

Section 2: Medical Necessity Questionnaire

Ambulance transportation is medically necessary only if other means of transportation are contraindicated or would be potentially harmful to the patient.

THE FOLLOWING QUESTIONS MUST BE ANSWERED BY THE MEDICAL PROFIESSIONAL SIGNING BELOW FOR THIS FORM TO BE VALID.

1. Can this patient be safely transported by private car or wheelchair van? ☐ YES ☐ NO
   If YES, please call our dispatch center and arrange for wheelchair van service
2. Is the patient able to get up from bed without assistance? ☐ YES ☐ NO
3. Is the patient able to sit up in a chair or wheelchair? ☐ YES ☐ NO
4. Is the patient able to ambulate? ☐ YES ☐ NO
5. Describe the patient's physical or mental condition that requires transportation by ambulance and any special instructions, including medications, oxygen or IV meds/fluids

_____

_____

6. ***In addition*** to completing questions 1-5 above, please check any of the following conditions that apply:

☐ Contractures	☐ Non-healed fractures	☐ Moderate/severe pain on movement
☐ Danger to self/others	☐ IV meds/fluids	☐ Special handling/isolation required
☐ Comatose	☐ Cardiac monitoring required	☐ Ventilator dependent
☐ Decreased LOC	☐ Airway monitoring required	☐ Pt at risk of falling
☐ Transfer to psych facility	☐ Seizure prone	☐ Requires O_2 monitoring / no portable O_2 available
☐ Morbid obesity	☐ Physical/chemical restraints	☐ Decubitus ulcers/wound precautions

Section 3: Signature of Physician or Healthcare Professional

I certify the above information is true and correct based on my evaluation of this patient and certify this patient requires transport by ambulance due to the reasons documented on this form. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) and Michigan Medicaid to support the determination of medical necessity for ambulance services.

Printed Name of Physician or Healthcare Professional: _____

Signature of Physician* or Healthcare Professional: _____

Date: _____ NPI: _____

*Medicare requires this form be signed by a physician for repetitive, scheduled transports.
*Michigan Medicaid requires this form be signed by a physician for all non-emergency transports.
*For non-repetitive, unscheduled ambulance transports, this form may be signed by any of the following healthcare professionals: Physician Assistant, RN, Nurse Practitioner or Discharge Planner.

Please fax this form to (313)-307-7259