WESTERLY AMBULANCE CORPS
30 Chestnut Street
Westerly, RI 02891

Physician Certification Statement for Medical Necessity

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

PLEASE PRINT CLEARLY AND HAVE PHYSICIAN SIGN WHERE INDICATED BELOW. COMPLETE ALL SECTIONS OF THIS FORM.

Section 1 – Beneficiary Information

Name: Last Name	First Name	Middle Initial
Diagnosis:		
DOB:	Sex	SSN
Date of Transport: ____/____/______	❑ If multiple transports required (Dialysis, Radiation, etc.) Check here to validate this PCS for Maximum of 60 days	______ Initial

Section 2 – Transportation Information

Transport to:	Unit/Bed	Discharge? Yes ❑ No ❑

Section 3 – Medical Necessity

Please check the appropriate medical condition(s) listed below which would necessitate transport by ambulance and make all other methods of transport contraindicated based on patient safety and health.

PLEASE CHECK ALL THAT APPLY.

❑ **Bed Confined: All three criteria below must be met to quality for bed confinement.**

1. Unable to ambulate.
2. Unable to get out of bed without assistance.
3. Unable to safely sit up in a wheelchair.
   a. Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate to severe muscular weakness and de-conditioning or severe pain on movement.
   b. Unable to sit in chair or wheelchair due to Stage II or greater decubitus ulcers:
   ❑ buttocks ❑ coccyx ❑ hip ❑ other

❑ Morbid Obesity requires additional personnel / equipment to handle.
❑ Suffers from paralysis: ❑ hemi ❑ quad ❑para
❑ Patient has contractures: ❑ upper ❑ lower ❑both
❑ Patient has non-healed fractures. Location: ____________________________________
❑ Exhibiting signs of a decreased level of consciousness: ❑ confused ❑combative ❑ lethargic ❑ comatose
❑ DVT requires elevation of a lower extremity.
❑ Seizure prone and requires trained monitoring.
❑ Patient requires Isolation Precautions; reason: ____________________________________
❑ IV medications/fluids required during transport.
❑ Cardiac / Blood Pressure monitoring required during transport. Specify: ____________________
❑ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport.
❑ Patient requires airway monitoring or suctioning. ❑ Portable ventilator required.
❑ Trained personnel required for administering, and /or regulating oxygen en route.
❑ Patient is a danger to self or others (requiring monitoring).
❑ Restraints (physical or chemical) anticipated or used during transport.
❑ Patient requires elopement precautions (flight risk or dementia).

Please list any Medical Hx /Dx which can help substantiate the above conditions: ____________________

Other Conditions not listed above:

Section 4 - Signature

I certify that the above information is true and correct based on my evaluation of this patient. I understand that information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination necessity for ambulance service.

Print Name of Person ordering Ambulance Service (Physician):		Date:
Signature of Physician or Medical Support Staff (Nurse, Social Worker):		Date:

Organized in 1917 as the Westerly Sanitary Corps, Inc.
Phone 401-596-4375 Fax 401-596-8942 www.westerlyambulance.org