



702-GEMS-911 • (702-436-7911)
Fax: 702-207-0599

PHYSICIAN CERTIFICATION STATEMENT

Medical Necessity for Non-Emergency Ambulance Transportation

- 2** Transport Date: _____ / _____ / _____
 (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range)
- 3** Origin: _____ **4** Floor/Unit: _____
- 5** Destination: _____
- 6** Patient Name: _____ **7** DOB: _____ **8** Sex: _____
- 9** HIC/Medicare Number: _____ **10** Physician Name: _____
- 11** Phone Number: _____ **12** Fax Number: _____

Complete by explaining the reason(s) why the patient requires non-emergency ambulance services.

13 Patient is unable to sit or travel in a wheelchair due to:

- 14** Monitoring/treatment is required **during** transport.
 (Please check off and explain in detail any of the following that would support the ambulance transport)
- Ventilator dependent (Please explain below)
 - IV Medications required en route (Please explain below)
 - EKG/ECG monitoring required en route (Please explain below)
 - Requires assistance to administer oxygen en route (Please explain below)
 - Requires suctioning/airway control en route (Please explain below)
 - Psychiatric Hold Requires Restraints Flight Risk
 - Risk of falling out of a wheelchair in motion due to: (Please explain below)
 - Isolation precautions due to: (Please explain below)
 - Orthopedic device that prevents transport by wheelchair or other means: (Please explain below)
- _____
- _____

III. What special services/treatments were needed and not available at sending facility? (Hospital to hospital only)

- 15** Services not available _____
- 16** Was the patient discharged from sending facility? Yes No

I certify that I am familiar with the patient's condition and have determined that the patient's medical record supports the ambulance transportation for the reason(s) specified. Ambulance service is hereby ordered.
 (For repetitive patients, **only** a physician may sign)

- Please check one:**
- 17** Physician Registered Nurse (R.N.) Discharge Planner Nurse Practitioner Physician Assistant CNS

_____ **18** Print Name _____ **19** Signature _____ **20** Date

Physician Certification Statement pursuant to CFR (Section 410, 40 (d) (2-3)
 Medicare Part B benefits are payable for ambulance services **only** when any other method of transportation is contraindicated by the patient's condition. The Centers for Medicaid Services requires documentation of the medical necessity for such services.

Physician Certification Statement (PCS) Cheat Sheet

What is a PCS form: A Physician Certification Statement (also known as a PCS form) is used to show why an ambulance was called to transport a patient. This form should be used on any patient with Medicare as their insurance provider, however it can also be used for any insurance provider to demonstrate **medical necessity for ambulance transportation.**

1) Incident Number - this is a field used by Guardian Elite Medical Services. Hospital staff do not need to fill out this field.

2) Transport Date - this is the date the transport is taking place. PCS forms are valid for up to 60 days from the original transport if a patient requires multiple ambulance rides during this 60 day period. When a patient requires multiple trips in the 60 day window, only the Patient's Physician can sign the provider section at the bottom of the form.

3) Origin - this is the name and address of the originating facility.

4) Floor/Unit - this is the floor or the unit the patient is located in. Examples might be Emergency Room, ICU, MedSurg, Operating Room, etc.

5) Destination - this is the name and address of the facility the patient is being transported to.

6) Patient Name - this is the legal name of the patient being transported.

7) DOB (Date of Birth) - this is the patient's date of birth.

8) Sex - this is the patient's gender or gender expression. Appropriate terms may include Male, Female, non-binary, transgender, or any other gender expression that the patient identifies themselves as.

9) HIC/Medicare Number - HIC or HICN stands for Health Insurance Claim Number. This may also be referred to as the MBI or Medicare Beneficiary Identification number. This is the patient's policy number from their insurance company.

10) Physician Name - this is the name of the physician who is treating the patient.

11) Phone Number - this is the phone number of the sending facility. This is important in case there are questions about the patient.

12) Fax Number - this is the fax number of the sending facility. This is important in case we need to send the PCS form back for additional information.

13) Patient is unable to sit or travel in a wheelchair due to - this is a sentence explaining why the patient requires ambulance transportation and cannot travel by any other means.

14) Monitor/treatment required during transport - if the patient is able to sit in a wheel chair, but requires specialty skills of an ambulance then this section is used. There is a list of treatments that may be performed by ambulance personnel.

15) Services Not Available - list the services that the patient will require at the other facility. For example, neurology, cardiology, gastroenterology, etc.

16) Was the patient discharged from the sending facility? - this is asking if the patient was officially discharged from the sending facility. An instance in which the patient may not be discharged would be a round trip ambulance ride.

17) Please Check One (Provider) - this is the provider who is certifying that the patient requires ambulance transportation. Only a Physician (MD or DO), Registered Nurse, Discharge Planner, Nurse Practitioner, Physician Assistant (PA), or Clinical Nurse Specialist (CNS) may sign for patients requiring a single ambulance ride. Patients who require multiple ambulance rides over a 60 day period, must have the PCS form signed by the physician.

18) Print Name - the printed name of the healthcare provider certifying that the patient requires ambulance transportation.

19) Signature - the signature of the healthcare provider certifying that the patient requires ambulance transportation.

20) Date - the date that the PCS form was signed.

To arrange for ambulance
transportation call

702-GEMS-911

(702-436-7911)

Once the PCS form is complete, please fax it to
702-207-0599

Do not have PCS form? Download one at <http://lasvegasambulance.com/pcs.pdf>