SUPERIOR AMBULANCE SERVICE, INC.

Physician's Certification Statement (PCS)

For Non-Emergency, Medical Transportation Services

Phone: (505) 247-8840 DISPATCH fax: (505) 836-7950 BILLING Fax: (505) 830-1260

Patient's Name _____ Date of Birth _____/_____/_____

Transport Date _____/_____/_____ Referring Physician: _____

Patient Picked Up At:_____ Transported to: _____

1) Is patient able to get up from bed without assistance? ☐ Yes ☐ No

2) Is patient able to ambulate? ☐ Yes ☐ No

3) Is patient able to sit in a chair or wheelchair? ☐ Yes ☐ No

NOTE: If patient can sit in a chair other than a specialty recliner, even if they are strapped in a wheelchair for any amount of time, they do not meet the national definition of "bed confined".

4) Is ambulance services required? ☐ Yes ☐ No

Personal vehicle, taxi or wheelchair van would not be appropriate because: Check all that apply.

- ☐ No upper body control
- ☐ Contractures
- ☐ Unconscious
- ☐ Trauma
- ☐ Drug or IV administration/monitoring
- ☐ Ventilator Dependent
- ☐ Isolation Precaution
- ☐ Cardiac Care
- ☐ Hostile/safety risk
- ☐ Restraints
- ☐ Chemical Restraint
- ☐ Decubitus ulcers Stage _____ Where _____
- ☐ Medicated prior to transport
- ☐ Trach w/02 / Suction needs
- ☐ Chest Tubes
- ☐ Airway control (Patients who are generally mobile with portable 02 would not meet criteria based solely on the need for 02.)
- ☐ Other: _____

5) If patient is being transferred to a higher level of care, please indicate what service is needed that the sending facility cannot provide:

_____

6) **If patient is being transported to an out of area behavioral health facility, please validate that this is the closest facility who is accepting this patient to provide the necessary care and that you verified none closer would accept the patient**. ☐ Yes ☐ No

7) Is this an outpatient transport? ☐ Yes ☐ No

I certify that the above information is true and correct based on my evaluation of this patient to the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services and Medicare to support this determination of medical necessity for ambulance services. I further certify that our institution has furnished care or other services to the above named patient. In the event that you are unable to obtain the signature of the patient or another authorized representative, pursuant to 42 C.F.R. §424.36(b)(4), I hereby sign on the patient's behalf.

CHECK CREDENTIALS THAT APPLY

❑ Physician, ❑ Physician Assistant, ❑ Nurse Practitioner, ❑ Clinical Nurse Specialist, ❑ Registered Nurse or ❑ Discharge Planner.

_____ _____ _____

Signature of Physician or Health Care Professional | Phone Number | Date Signed

_____ _____

Print Name | Fax Number

Please Note: ***All Dialysis & repetitive patient transports require the signature of a Physician for transport to and from treatment.***

Repetitive patient transport PCS good for 60 days from 1st date of transport

Revised 03-15