# Non-Emergency Ambulance Transportation Order/Physician Certification Statement (PCS)

Patient Information:

Last name: ______________________________ First name: ____________________________ MI: ____

DOB (MM/DD/YYYY):_______________ Gender: __ M __ F __ Other Medicare ID:_________________

Certifying physician / practitioner information: (if different from person signing below)

*Last name:___________________________ First name:______________________ MI:___ Suffix:____*

*NPI:*__________________________ Place of employment:____________________________________

Address:______________________________________________________________________________

City:____________________________________ State:______ Zip:______________

Telephone number and extension: (___)_____-________ x ________

Direct address:_______________________________________________________________________

*Date of order, if different from signature date (MM/DD/YYYY):_________________*

Start date:________________________ End date:____________________ Round trip: ___ Yes ___ No

Transport from ____ Home, or ___________________________ To:___________________________

Number of transports requested in a 60-day period:______

Procedure Code:______________________ *Modifier 1:_______________ Modifier 2:_____________*

Purpose of transport [service(s) that cannot be provided in the current setting]:

___ Dialysis ____ Wound care ___ Radiation therapy ___ Chemotherapy ___ O&P services

___ Imaging ____ Other, describe:_______________________________________________________

Reason(s) that non-emergency ground transport by ambulance is required. Supporting documentation for any checked item must be maintained in the patient's medical record. Check all that apply:

Mobility

___ Bed confined (all three criteria must be met):
1) Unable to ambulate,
2) Unable to get out of bed without assistance,
3) Unable to safely sit in a chair or wheelchair

___ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning

___ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)

Musculoskeletal

___ Non-healed fractures requiring ambulance

___ Contractures that impair mobility and result in bed confinement

___ Incapacitating Osteoarthritis

___ Severe muscular weakness and de-conditioned state precludes any significant physical activity

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Musculoskeletal (continued)
____ Orthopedic device required in transit
____ Amputation(s)

Cardiovascular
____ CVA with sequelae (late effect of CVA) that impair mobility and result in be confinement
____ DVT requires elevation of lower extremity

Neurological
____ Spinal Cord Injury – Paralysis
____ Progressive demyelinating disease
____ Moderate to severe pain on movement

Wound
____ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
____ Chronic wounds requiring immobilization

Attendant required during transport
____ Morbid obesity requires additional personnel/equipment to handle
____ Third party attendant required to regulate or adjust oxygen en route
____ Special handling en route – isolation
____ IV medications/fluids required during transport
____ Restraints (physical or chemical) anticipated or used during transport

Mental
____ Danger to self or others
____ Confused, combative, lethargic, comatose

Other
____ Other, *describe:*______________________________________________

**I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date(s) of service.**

Physician, allowed NPP, LSW, case manager, or discharge planner signature, name, date signed and NPI:

Signature: ______________________________________________

Name (Printed): ______________________________________________

Date (MM/DD/YYYY): ____________________ NPI:______________________________

*For accurate insurance claims please fill out form in it's entirety, missing information on this form can lead to a denial of claims on Medicare's behalf.*

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