

FIRST RESPONSE AMBULANCE
Physician Certification Statement (PCS)

Date: ___/___/___

Call ID# _____

Patient Name: _____ Age: _____

Date of Service: _____

Telephone Number: _____

Patient transported from: _____

Patient transported to: _____

In my professional medical opinion, this patient requires transport by Ambulance. This patient's medical condition necessitates this level of care and make all other means of transportation contraindicated based on patient's health safety.

A) This patient is currently bed-confined per Medicare/HCFR regulations __ Yes __ No

The definition of Bed Confinement is: The inability to get up from bed without assistance, ambulate, and sit in a chair including a wheelchair.

B) The patient does not meet bed-confined criteria as defined above. Nonetheless, the patient's medical condition necessitates transportation by Ambulance only.

Please use the following checklist and the Detail section to explain in detail why the patient requires an ambulance.

This patient:

- | | |
|--|--|
| <input type="checkbox"/> is paralyzed and unable to sit in a wheelchair | <input type="checkbox"/> has decubitus ulcers and requires wound |
| <input type="checkbox"/> requires airway monitoring and suctioning | <input type="checkbox"/> is ventilator dependent |
| <input type="checkbox"/> req. isolation procedures (MRSA, VRE, etc) | <input type="checkbox"/> is contracted & must be moved by stretcher |
| <input type="checkbox"/> has continuously running intravenous fluids/RX | <input type="checkbox"/> req. car. EKG or other physiologic monitor |
| <input type="checkbox"/> patient unable to self-administer necessary O2 | <input type="checkbox"/> exh. overall wasting & is too weak to sit up |
| <input type="checkbox"/> is comatose and Reuters medical monitoring | <input type="checkbox"/> patient is hostile/ potentially combative |
| <input type="checkbox"/> patient in chronic debilitating pain | <input type="checkbox"/> unable to sit in a wheelchair safely for dur. |
| <input type="checkbox"/> patient is abnormally stiff and rigid and can't sit | <input type="checkbox"/> requires monitoring from medial personnel |

Details: (Define the reason(s) contributing to any of the checked items or bed-confinement)

I certify that the above information is true and correct based on my evaluation of this patient. I understand that the information contained herein shall be used by the Department of Health and Human Services/HCFR to support the determination of medical necessity for ambulance transportation. The execution of this document does not assure that any payment shall be made for services rendered to your patient.

Print Name

Signature

Date

Please Fax this form to (718) 239-4900
Phone (718) 863-8800