ATTENTION
Medicare, Medicaid and ALL commercial insurances require this form to be completed in its entirety by the patient's **medical provider** in order to be properly billed.

Concord EMS
Compassion Care Accountability

24 HOUR DISPATCH
734-947-9400
313-386-9400
248-967-9400
FAX 734-947-1911

ALL HIGHLIGHTED AREAS MUST BE COMPLETE FOR FORM TO BE VALID

PHYSICIAN CERTIFICATION STATEMENT

SECTION I– GENERAL INFORMATION

_____Single Transport _____Multiple Transports HMO Pre-Authorization #_____

Patient Name:_____ Date of Birth:_____ Medicare #:_____

Is the patient's stay covered under Medicare Part A (PPS/DRG)? ☐ YES ☐ NO Medicaid #: _____

PCS is valid for round trips on this date and for all repetitive trips in the 60-day range for Medicare and 30-day range for Medicaid as noted below

Transport/Start Date: _____ Origin:_____ Destination:_____

SECTION II– MEDICAL NECESSITY QUESTIONNAIRE

Ambulance transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. **The following questions must be answered by the medical professional signing below for this form to be valid**

Required Narrative– please complete one of the following statements:

This patient requires transport on a cot, in an ambulance and can not go by any other means due to: (diagnosis) _____

_____

This is a hospital-to-hospital transfer: sending facility does not provide the following services/procedure: _____

_____

Is this patient "bed confined" as defined below? ☐ YES ☐ NO

To be "bed confined" the patient must satisfy all three of the following conditions: (1) Unable to get up from bed without assistance, AND (2) unable to ambulate, AND (3) unable to sit in a chair or wheelchair

Can this patient safely be transported by car or wheelchair van (i.e. seated during transport, without a medical attendant or monitoring?)
☐ YES ☐ NO

Please check all that apply:

__ requires continuous oxygen and monitoring by trained staff
__ requires airway monitoring or suction
__ requires cardiac monitoring or IV maintenance
__ comatose and requires trained monitoring
__ is seizure prone and requires trained monitoring
__ is exhibiting signs of decreased level of consciousness
__ requires restraints
__ contractures (upper, lower)
__ fracture of the _____
__ has decubitus ulcers & requires wound precautions
__ requires isolation precautions (VRE, MRSA, etc.)
__ should not or is unable to stand, pivot or ambulate
__ cannot safely assist with moving them self
__ can tolerate wheelchair but inadvisable due to other condition on this form
__ patient is ventilator dependant
__ paralysis (hemi, semi, quad)
__ requires psychiatric care
__ other reason:_____

Physician Certification/Authorization: I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.

Print Physician's Name:		**Ordering Physician's NPI**	
Title:	**___ Attending Physician**	**___ Physician Assistant**	**___ Clinical Nurse Specialist**	**___ Social Worker**
	___ Nurse Practitioner	**___ Registered Nurse**	**___ Discharge Planner**	**___ Case Manager**
Physician's Signature:		**Date Signed:**	

***** For unscheduled or scheduled non-repetitive transports an individual (employed by the facility where the beneficiary is being treated) who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished may sign the authorization.**