Medical Necessity for Non-Emergency Ambulance Transport
Provider Certification Statement

Patient's First & Last Name:		Transport Date:
Gender: ☐Male ☐Female	Date of Birth:	Social Sec. #:

☐ Check here if multiple transports are required for a condition such as dialysis or radiation (list condition below).
This PCS is valid for a maximum of 60 days and must be signed by a physician.

Medical Condition at time of transport that requires patient to be transported by ambulance:

Is patient 'bed confined'? *as defined by CMS which requires all three of the following to be true:*

☐ Unable to get up from bed without assistance
☐ Unable to ambulate without assistance Due to: _____
☐ Unable to sit in chair _____

Bed confinement must be true before, during and after the transport

Medical Necessity for ambulance transport *(select all that apply)*

Patient requires monitoring / care by trained medical personnel during transport

☐ Requires cardiac/hemodynamic monitoring due to: _____
☐ Requires intravenous fluids and/or medications
List IVF/rate or medication/rate: _____
☐ Requires airway/ventilator monitoring due to: _____
☐ Requires supplemental oxygen and unable to self-administer
List reason why patient is not able to self-administer: _____
☐ Patient is a danger to self or others due to mental disorder
List condition (psychosis, delirium, suicidal, cognitive risk, etc.): _____
☐ Patient is confused/Altered Mental Status
☐ Requires infection precautions/isolation. List condition (MRSA, VRE, etc.): _____

Patient is unable to sit and safely support self in wheelchair due to:

☐ Wounds/decubital ulcers. Location & stage/depth: _____
☐ Fracture or musculoskeletal injury. Location & type: _____
☐ Contractures. Location & severity: _____
☐ Orthopedic device or surgical drain (neck immobilizer, backboard, pins, brace, wedge, etc.)
Describe: _____
☐ Other reason why patient cannot be transported in wheelchair: _____
_____

Other:

☐ Morbid obesity requests/requires additional personnel/equipment. Height: _____ Weight: _____
☐ Other reasons. Explain:

Certifying Provider Information

I certify that the above information is true and correct based on my evaluation of this patient. I believe the patient requires transport by ambulance and that other means of transport are contraindicated.

Signature: _____ Date: _____
☐MD/DO ☐PA ☐NP ☐RN ☐Clinical Nurse Specialist ☐Discharge Planner

Printed Name: _____ Telephone: _____