

Physician's Certification Statement (PCS)
for Non-Emergency Medical Transportation Services

Initial Transport Date: ___ / ___ / ___ Repetitive Transport Expiration Date (Max 60 Days) ___ / ___ / ___

Patient's Name: _____

Medicare #: _____ ()

Ambulance Company Name _____

Patient Picked Up At: _____

Patient Transported To: _____

Physician or Health care Professional's Name: _____

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

ALL THREE QUESTIONS MUST BE ANSWERED OR THIS PCS WILL BE CONSIDERED INVALID

1) Is this patient Bed-Confined as defined by Medicare Regulation above? Yes No

2) What **MEDICAL CONDITION** does this patient present **ON THE DATE OF AMBULANCE TRANSPORTATION** that requires them to be transported on a stretcher in an ambulance:

3) Can this patient be safely transported by any other means? Yes No

WHEN COMPLETED, SIGN BELOW AND FAX TO NUMBER AT BOTTOM LEFT

I certify that the above information is true and correct based on my evaluation of this patient, 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 the determination of medical necessity for ambulance services.

Signature of Physician or Healthcare Professional

Phone Number

Date Signed

Fax Completed Form to

1-866-513-1094

Questions ? Please call

(615) 451-0429 ext 140

PLEASE FAX OR RETURN THIS PCS WITHIN 48 HOURS