Run #

HVA	JCA	MCA	LCA	ACA
Huron Valley Ambulance	**Jackson Community Ambulance**	**Monroe Community Ambulance**	**Lenawee Community Ambulance**	**Albion Community Ambulance**
(734) 994-4111 (734) 453-1011 (800) 872-1111 Fax: (734) 971-0323	(517) 787-5700 (800) 872-1111 Fax: (734) 971-0323	(734) 242-5510 (800) 872-1111 Fax: (734) 971-0323	(517) 263-1633 (800) 872-1111 Fax: (734) 971-0323	(517) 629-9431 (800) 872-1111 Fax: (734) 971-0323

AMBULANCE TRANSFER FORM (PCS)

Physician Certification of Medical Necessity Statement

Initial Transport Date:____/____/____ Certification Expiration Date (Max. 60 days):____/____/____

(Note: A PCS form may be effective for 60 days for repetitive transports only.)

Patient Name: ______________________________ DOB: ____/____/____

Supporting Diagnosis: ______________________________

Transport From: __________________ Transport To: __________________

Attending Physician: ______________________________

Bed Confined? **YES** or **NO**. CMS Definition: *Inability to get up from bed without assistance, ambulate, and sit in a chair, including a wheelchair (must meet all criteria).*

(Circle one)

Please check all that apply:

- ☐ requires continuous oxygen & monitoring by trained staff
- ☐ requires airway monitoring or suctioning
- ☐ requires cardiac monitoring or IV maintenance
- ☐ comatose and requires trained monitoring
- ☐ is seizure prone and required 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 stand, pivot or ambulate or is unable to safely assist with moving themselves.
- ☐ can tolerate wheelchair but inadvisable due to other conditions indicated on this form
- ☐ patient is ventilator dependant
- ☐ paralysis (hemi, semi, quad)
- ☐ requires psychiatric care
- ☐ Other reason: ______________________________

Transfers to another facility, check all that apply:

- ☐ this transfer has been requested by the patient/family
- ☐ this transfer has been requested by the patient's physician
- ☐ no appropriate bed is available at our facility
- ☐ requires speciality physician not available at our facility—explain: __________________
- ☐ requires special services not available at our facility—explain: __________________

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required. I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge. I understand that this information will be used by the Centers for Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services.

Print name: ________________________

Sign name: ________________________

- ☐ Physician
- ☐ Physician Assistant.
- ☐ Registered Nurse
- ☐ Nurse Practitioner
- ☐ Certified Nurse Specialist
- ☐ Discharge Planner

____/____/____
Date Signed

(MEDICAID: Only a Physician, Physician's Assistant or Nurse Practitioner may sign).

(Note: An LPN is not authorized by Medicare to sign this form unless you are a Discharge Planner).

INFORMATION REGARDING AMBULANCE TRANSFERS OF PATIENTS

Information: *Medicare and Medicaid pay for medically necessary transportation to the nearest appropriate facility. An "appropriate facility" is defined as a facility which is generally equipped to provide the needed care for the illness or injury involved. In the case of a hospital, it also means that a physician or specialist is available to provide the necessary care required to treat the patient's condition. The fact that a particular physician does not have staff privileges in a hospital is not a consideration in determining whether the hospital is appropriate. Payment for ambulance transport to a more distant hospital solely to avail a patient of the services of a specific physician or specialist will normally be denied and the patient will be responsible for their ambulance charges.*

The fact that a more distant institution is better equipped to care for the patient also does not make the transport appropriate if the care could have been delivered in the closer hospital. Transport to a more distant hospital is warranted, however, if the patient's condition requires a higher level of clinical care or other specialized service available only at the more distant hospital. The same factors would also pertain to transportation to a nursing facility which is not closest.

If you are requesting a transport to a further facility due to family preference or insurance reasons, the patient and/or the family may be responsible for the base rate and/or mileage charges. Please inform the patient of this.

3/19/09