# SUPERIOR AMBULANCE SERVICE, INC.

## Physician's Certification Statement (PCS)

**Phone: (505) 247-8840 DISPATCH fax: (505) 836-7950 BILLING Fax: (505) 830-1260**

Patient's Name _____ Date of Birth _____/_____/_____

Transport Date _____/_____/_____
Location address/Facility
Patient Picked Up:_____

Referring Physician: _____
Address/Facility
Transported to: _____

1) Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. Supporting documentation for any boxes checked must be maintained in the patient's medical records. Personal vehicle, taxi or wheelchair van would not be appropriate because: Check ALL that apply.

☐ Bed Confined * ALL THREE must be met to qualify for bed confinement: 1) Unable to ambulate; 2) Unable to get out of bed without assistance; 3) Unable to safely sit up in a wheelchair
☐ Unable to maintain erect sitting position in a chair for the time needed to transport, due to moderate muscular weakness, de-conditioning or no upper body control.
☐ Assistance required to apply or regulate oxygen en route.
☐ Chest Tubes
☐ Contractures
☐ Unconscious
☐ Trauma
☐ Confused, combative, lethargic, comatose
☐ Isolation Precaution List: _____
☐ Trach w/O2 / Suction needs
☐ DVT requires elevation of lower extremity
☐ Restraints (physical or chemical) anticipated or used during transport.
☐ Moderate to severe Pain on movement
☐ Danger to self or others-monitoring
☐ Flight risk
☐ Drug or IV administration/monitoring
☐ Decubitus ulcers Stage _____ Location _____
☐ Medicated for transport with:_____
☐ Morbid obesity requires additional personnel/equipment to handle
☐ Risk of falling off wheelchair or stretcher while in motion. (not related to obesity)
☐ Non healed fractures
☐ Cardiac Care
☐ Ventilator Dependent
☐ Other/condition _____

2) **Hospital to Hospital ONLY:** Please indicate what service/treatment is needed that the sending facility cannot provide:

_____

_____

3) At time of transport was patient discharged from sending facility? ☐ Yes ☐ No

PLEASE NOTE: **If patient is being transported to an out of area behavioral health facility, complete addendum.**

I certify that the above information is true and correct based on my evaluation of this patient to 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 this determination of medical necessity for ambulance services. I further certify that our institution has furnished care or other services to the above named patient. In the event that you are unable to obtain the signature of the patient or another authorized representative, pursuant to 42 C.F.R. §424.36(b)(4), I hereby sign on the patient's behalf.

**CHECK CREDENTIALS THAT APPLY**

❑ Physician, ❑ Physician Assistant, ❑ Nurse Practitioner, ❑ Clinical Nurse Specialist, ❑ Registered Nurse or ❑ Discharge Planner.

_____ _____ _____
Signature of Physician or Health Care Professional | Phone Number | Date Signed

_____ _____
Print Name | Fax Number

**Please Note: *All Dialysis & repetitive patient transports require the signature of a Physician for transport to and from treatment.***
**Repetitive patient transport PCS good for 60 days from 1st date of transport**

PLACE PATIENT ID STICKER HERE