Physician Certification Statement (PCS) for Ambulance Transport

Step #1: Fax to (559) 600-7623 and include a facesheet and 5150 form if on a hold.
Step #2: Contact TransComm at (559) 600-7807 to schedule an ambulance transport.

Section 1 – Patient Information

Last Name:	First Name:	Date of Birth:

Section 2 – Transport Information

Date:	From:	To:

If outside of area (Fresno/Kings/Madera/Tulare), why is transport to a more distant facility needed?

Section 3 – Medical Necessity Information

Medical necessity is established when the patient's condition is such that the use of any other method of transportation would be contraindicated. In other words, no other transportation type could be used without endangering the patient's health. If the patient can be transported by any other means (e.g., litter van, wheelchair van, car, taxi, etc.) then medical necessity for an ambulance does not exist. It does not make a difference whether the other type of transportation is actually available in the locality at the time of service.

If patient <u>does NOT meet ambulance medical necessity</u>, please sign below to authorize billing to the requesting party.

Name: Signature: Date:

If patient <u>does meet ambulance medical necessity</u>, select all that apply below:

<u>Monitoring Requirements</u>

- ☐ Airway monitoring
- ☐ Abnormal vital signs monitoring
- ☐ Cardiac monitoring
- ☐ Mental status monitoring due to abnormal behavior, altered mental status, CVA, medication, or syncope
- ☐ Orthopedic/medical device monitoring
- ☐ Palliative support related to hospice care
- ☐ Passive/manual restraint to prevent patient injury or medical device movement/tampering
- ☐ Flight risk due to dementia or altered mental status and unable to follow commands
- ☐ Flight risk due to 5150 hold (must include a copy of the 5150 form)
- ☐ Isolation/infection precautions due to: _____

<u>Treatment Requirements</u>

- ☐ Oxygen administration (medical attendant required to regulate)
- ☐ Suctioning as needed
- ☐ Restraints needed during transport
- ☐ IV meds or fluid
  Describe:_____
- ☐ Other treatment/device not listed
  Describe:_____

<u>Describe in detail why the patient can only be transported by ambulance.</u> Specifically, why a medical attendant in the back of the ambulance is necessary to monitor or treat the patient as indicated above.

<u>Is the patient bed-confined? If so, describe why:</u> Check one: ☐ YES or ☐ NO

"Bed-confined" means unable to stand, ambulate <u>and</u> sit in a chair.

Section 4 – Signature of Physician (for Medi-Cal) or other Healthcare Professional

I certify that the above information is accurate and complete based on my evaluation of this patient and demonstrates that the patient requires ambulance transport because other forms of transport would endanger the patient's health. I understand that this information will be used by Medicare or Medi-Cal to support the determination of medical necessity for transport services. I represent that I have personal knowledge of the patient's condition at the time of transport. **(<u>For all Medi-Cal patients, this form must be signed by a physician</u>)**

⇨ _____ _____

Signature of Physician (for Medi-Cal) or other Healthcare Professional — Date

_____ _____

Print Name — NPI/License Number

☐ Physician	☐ Nurse Practitioner	☐ Clinical Nurse Specialist
☐ Physician's Assistant	☐ Registered Nurse	☐ Discharge Planner

Clear Print

Revised 04/2016