

Run #

Matching #

American Twp. Fire Dept.
105 W. Main St.
Elida, Ohio 45807
419-339-3921

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).*
(Check one)

PLEASE CHECK ALL THAT APPLY:

- | | |
|---|---|
| <input type="checkbox"/> requires continuous oxygen & monitoring by trained staff | <input type="checkbox"/> contractures (upper, lower) |
| <input type="checkbox"/> requires airway monitoring or suctioning | <input type="checkbox"/> has decubitus ulcers & requires wound precautions |
| <input type="checkbox"/> requires cardiac monitoring or IV maintenance | <input type="checkbox"/> requires isolation precautions (VRE, MRSA, etc.) |
| <input type="checkbox"/> comatose and requires trained monitoring | <input type="checkbox"/> unable to be transported safely by wheelchair due to other conditions indicated on this form |
| <input type="checkbox"/> is seizure prone and requires trained monitoring | <input type="checkbox"/> patient is ventilator dependant |
| <input type="checkbox"/> is exhibiting signs of decreased level of consciousness | <input type="checkbox"/> paralysis (hemi, semi, quad) |
| <input type="checkbox"/> requires restraints | <input type="checkbox"/> requires psychiatric care |
| <input type="checkbox"/> fracture of the _____ | |
| <input type="checkbox"/> Other reason: _____ | |

TRANSFER TO ANOTHER FACILITY, CHECK ALL THAT APPLY:

- | | |
|---|--|
| <input type="checkbox"/> this transfer has been requested by the patient/family | <input type="checkbox"/> this transfer has been requested by the patient's physician |
| <input type="checkbox"/> no appropriate bed is available at our facility | |
| <input type="checkbox"/> requires speciality physician not available at our facility — explain: _____ | |
| <input type="checkbox"/> 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.

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

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

Print Name: _____

Sign Name: _____

Date Signed: _____ / _____ / _____

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.

02/07/13