



# AMBULANCE PCS



## \*Physician Certification Statement\* for Ambulance Transportation

### Section 1 – Beneficiary Information

Patient Name: \_\_\_\_\_

Date of Transport: \_\_\_\_\_

Medicare #: \_\_\_\_\_

### Section 2 – Medical Necessity Information (to be completed by physician)

- Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated (i.e., other means of transportation would endanger the health of the patient).
- For non-emergency transportation, a patient who is bed confined is assumed to meet the criteria for ambulance transportation. All of the following criteria must be met by the condition of the patient at the time ambulance services are provided to be considered bed confined:

1. Is the beneficiary unable to get up from bed without assistance?  
 Yes       No
2. Is the beneficiary unable to ambulate?  
 Yes       No
3. Is the beneficiary unable to sit in a chair or wheelchair?  
 Yes       No

If you answered **yes** to all of the above questions, please describe the condition(s) of the patient that meets the above criteria.

\_\_\_\_\_

If you answered **no** to any of the above, please describe why other means of transportation are contraindicated.

\_\_\_\_\_

### Section 3 – For Hospital to Hospital Transfers Only

Is the patient being transferred to a higher level of care?  Yes  No

If the answer is yes, the following items must be completed.

- (A) Please list/describe facilities or procedures required/available at destination facility not available at originating facility? \_\_\_\_\_
- (B) Was the patient discharged at originating facility?  Yes  No
- (C) Was the patient transported to the closest appropriate facility?  Yes  No

### Section 4

Print the name of the physician ordering ambulance transportation: \_\_\_\_\_

UPIN: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I certify that the above information represents an accurate assessment of the patient's medical condition(s) and that in my professional medical opinion, this patient requires transport by an ambulance and should not be transported by any other means. I understand that this information will be used by the Health Care Financing Administration to support the determination of medical necessity for non-emergency ambulance services.*