VITAL LINK TRANSPORT 404-500-1039
Physician's Certification Statement (PCS)

EMS Run # _____ Booklet ID#_____

SECTION 1 – GENERAL INFORMATION

Transport Date: ____/____/____

Patient's Name:_____Date of Birth: ____/____/____ Medicare #: _____

Origin Name / Address: _____

Destination: _____ City _____ St _____ Zip _____

Is destination the closest appropriate facility? Yes No

Is destination patient or family choice? Yes No

Is patient being returned to area of original transfer? Yes No

Please circle yes or no under the corresponding question.

If the above does not apply for destination choice please enter it here: _____

If this is a hospital to hospital transfer , describe services needed at 2nd facility not available at 1st facility:_____

If hospice patient, is this transport related to the patients terminal illness: Yes No _____

SECTION II – MEDICAL NECESSITY QUESTIONAIRE

Ambulance Transportation is medically necessary only if the other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "Bed Confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition. The following questions must be answered by the medical professional signing below for this form to be valid.

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

2) ☐ YES or ☐ NO Is this patient "bed confined" as defined below?

To be "bed confined the patient must satisfy ALL three of the following conditions:

(1) Unable to get up from bed without assistance AND

(2) Unable to ambulate AND

(3) Unable to sit in a chair or wheelchair.

3) ☐ YES or ☐ NO Can this patient safely be transported by car or wheelchair van? (i.e., seated during transport without a medical attendant or monitoring?)

4) *In addition* to completing questions 1-3above, please check any of the following conditions that apply:

- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Patient is confused
- ☐ Patient is comatose
- ☐ Moderate/Severe pain on movement
- ☐ Danger to self/other
- ☐ IV meds/fluids required
- ☐ Patient is combative
- ☐ Need or possible need for restraints
- ☐ DVT requires elevation of lower extremity
- ☐ Medical attendant required
- ☐ Requires oxygen-unable to self-administer
- ☐ Special handling/isolation/infection control precautions required
- ☐ Unable to tolerate seated position for time needed to transport
- ☐ Hemodynamic monitoring required en-route
- ☐ Morbid obesity required additional personnel/equipment to safely handle patient
- ☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) required special handling during transport
- ☐ Other, (specify)

_____

_____

_____

_____

_____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that any other form of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR 424-36(b)(4). In accordance with 42 CFR 424-37, the *specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows.*

_____

_____

Signature of Physician or Helathcare Professional

____/____/_____:_____AM/PM

Date Signed (For scheduled repetitive transports, this form is not valid for transports performed more than 60 days after this date).

_____

Printed Name and Credentials of Physician or Healthcare Professional(MD, DO, RN, etc.)

*Form must be signed only by patient's attending physician for scheduled, repetitive transports.For non-repetitive, unscheduled ambulance transports, if unable to obtain the sinatureof the attendiang physician, any of the following may sign(please check appropriate box below):

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