



Physician's Certification Statement (PCS)

Non-Emergency Ambulance Transportation

Aetna Ambulance Service, Inc.

PO Box 1150, Manchester, CT 06045-1150

Office Phone: (860) 533-2067

Dispatch Phone: (860) 247-6792

Office Fax: (860) 643-0759

Dispatch Fax: (860) 240-7574

Patient Name: _____ Medicare #: _____

Patient DOB: _____ Date of Service: _____

Check ALL applicable reason(s) why a transport by ambulance is required:

Physical and Mobility Issues

- The patient is "bed-confined" under CMS guidelines due to the fact that they are unable to get up from bed without assistance AND unable to ambulate AND unable to sit in a chair or wheelchair.
- Frail, debilitated, extreme muscle atrophy AND therefore at risk of falling out of wheelchair while in motion.
- Suffers from contractures. Upper extremities ____, Lower extremities ____, Fetal ____.
- Suffers from paralysis. Hemiplegia ____, Quadriplegia ____, Paraplegia ____.
- Becomes hemodynamically unstable suddenly, orthostatic hypotension.
- Unable to sit for transport without risk to recent orthopedic surgery.
- Recent lower limb amputee. Date of amputation: ____--____--____
- Must remain immobile because of an unset or non-healed fracture of the _____.
- DVT requires elevation of a lower extremity.
- Moderate to severe pain on movement.
- Orthopedic device (backboard, halo, pins in traction, etc.) requiring special handling during transport.
- Morbid obesity effecting ability to safely travel in a wheelchair ____ lbs or ____ kgs

Mental Status Issues

- Pt requires 1:1 supervision due to: advanced dementia ____, late stage Alzheimer's ____, significant altered mental status ____, decreased level of consciousness ____. GCS: _____
- Comatose or vegetative and requires trained personnel to monitor condition during transport.
- Requires supervision during transport (check all that apply):
____ Danger to self and/or others, ____ Aggressive or unpredictable behavior.
____ May require restraint. Chemical ____, Physical ____, Verbal ____. ____ Flight risk.

Medical Issues

- Requires assistance in the administration of oxygen. Liters per minute (LPM): _____
- Pt requires (____ EKG monitoring) or (____ IV infusion or maintenance) during transport.
- Requires wound care precautions such as care and positioning:
____ Decubitus or stasis ulcers (Stage ____, Size ____). ____ Wound vac applied
____ Wound location: Buttocks ____, Coccyx ____, Sacral ____, Back ____, Hip ____, Other _____
- Recent and/or residual CVA or other neurological deficit effecting ability to safely sit upright.
- Actively seizure prone and requires trained personnel to monitor condition during transport.
- Requires isolation precautions /special handling during transport for VRE, C-Diff, MRSA sputum/wound etc.
- Medicated or sedated and needs trained personnel to monitor condition during transport.
- Requires airway monitoring and/or suctioning during transport.

- None of the above criteria pertain and the patient is a candidate for wheelchair van, if available.

In my professional medical opinion, unless otherwise stated, this patient requires transport by ambulance and should not be transported by other means. I certify that the above information is true and correct based upon my evaluation of this patient, to the best of my knowledge and professional training. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services.

Printed Name

Signature

Date

Circle One: MD, DO, PA-C, APRN, RN, CNS, Discharge Planner

ONLY AN MD CAN SIGN FOR REPETITIVE TRANSPORTS SUCH AS DIALYSIS