Alliance
Mobile Health

2045 Austin Drive
Troy, Michigan 48083
Dispatch: 888.843.3772

REPETITIVE 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 and MUST be signed by a physician.)

Patient Name: ______________________________ DOB: _____/_____/_____

Supporting Diagnosis: ______________________________

Transport From: ______________________________ Transport To: ______________________________

Attending Physician: ______________________________

Bed Confined? **YES** or **NO** (Circle one)

(CMS Definition: Inability to get up from bed without assistance, ambulate, and sit in a chair, including a wheelchair.)

Please check all that apply:

- ❑ Requires continuous oxygen & monitoring by trained staff
- ❑ Requires airway monitoring or suctioning
- ❑ Requires cardiac monitoring or IV maintenance
- ❑ Comatose and requires trained monitoring
- ❑ Is exhibiting signs of decreased level of consciousness
- ❑ Requires restraints
- ❑ Contractures (upper, lower)
- ❑ Fracture of the ______________________________
- ❑ Other reason: ______________________________
____
- ❑ Has decubitus ulcers & requires wound precautions
- ❑ Requires isolation precautions (VRE, MRSA, etc.)
- ❑ Should not stand, pivot or ambulate, or is unable to safely assist with moving themselves
- ❑ Can tolerate wheelchair but inadvisable due to other conditions indicated on this form
- ❑ Patient is ventilator dependant
- ❑ Paralysis (hemi, semi, quad)
- ❑ Requires psychiatric care

Transfers to another facility, check all that apply:

- ❑ This transfer has been requested by the patient/family
- ❑ No appropriate bed is available at our facility
- ❑ This transfer has been requested by the patient's physician
- ❑ Requires specialty physician not available at our facility-explain:
- ❑ 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.

Print name: ______________________________ Date Signed: ______________________________

Sign name: ______________________________ NPI# ________

*Signature of Ordering Physician----**CAN ONLY BE SIGNED BY A PHYSICIAN***