NOGA AMBULANCE SERVICE INC.

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Physicians Certification Statement (PCS)

NOGA FAX #: 724-656-0794 NPI# 1376538793

This certification is required for all non-emergency scheduled and non-emergency unscheduled ambulance and/or wheelchair van transport(s). This applies to Repetitive Transports and/or One-Time Transport(s).

Today's Date: Date of Transport:

Patient's Name: ID#:

Transported From: Department:

Transported To: Department:

In order for ambulance and/or wheelchair van services to be covered, they must be medically necessary and reasonable. Medical necessity is established when the patient's condition is such that transportation by any other means is contraindicated. Please complete the questions below in order for the claim to be evaluated for coverage criteria:

Check all that apply

- ☐ Bed Confined (All three criteria below must be met to qualify for bed confinement. This is required for ambulance transport)
  1. Unable to ambulate, and
  2. Unable to get out of bed without assistance, and
  3. Unable to safely sit up in a wheelchair due to one of the following;
     - ☐ Unable to maintain an erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning
     - ☐ Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- ☐ Confused, combative, lethargic, comatose
- ☐ Moderate to severe pain on movement
- ☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Orthopedic device (backboard, halo, use of pins in traction) requiring special handling in transport.
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen enroute. *(This alone does not meet the requirement for ambulance transport, please include other reasons to support medical necessity.)*
- ☐ Cardiac/Hemodynamic monitoring required during transport.
- ☐ I.V. medications/fluids required during transport
- ☐ Danger to self or others-monitoring
- ☐ Danger to self or others-seclusion/flight risk
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Special Handling enroute – Isolation
- ☐ DVT requires elevation of a lower extremity
- ☐ Morbid Obesity requires additional crew assistance to lift/move
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ☐ Suffers from paralysis or contractures.______Lower Extremities _______Fetal
- ☐ Has decubitus ulcers and requires wound precautions.___Buttocks______Sacral_____Back______Hip_______Other
- ☐ Other, please explain____

☐ **Check if patient CAN be safely transported in a Wheelchair Van and seated for duration of transport without medical attendant**

I certify that the above information represents an accurate assessment of the patient's medical condition(s) and that in my professional 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 Centers for Medicare Services to support the determination of medical necessity for ambulance service.

Medicare requires via 42 CFR Part 410.40(d) that ambulance providers obtain a Certificate of Medical Necessity signed by the patient's physician for the provision of non-emergency ambulance transportation. This form has been designed to assist the physician, the facility, the beneficiary and the ambulance provider to determine if Medical Necessity has been met.

☐ Medical Doctor ☐ Physicians Assistance
☐ Registered Nurse ☐ Nurse Practitioner
☐ Discharge Planner ☐ Clinical Nurse Specialist

Practitioners Name: (please print above) Please place a check mark in front of appropriate title

Practitioners Signature: Date:

This form may be signed by a R.N., Nurse Practitioner, Discharge Planner, Physician Assistant, Clinical Nurse Specialist or Physician for one time transports. A Physician signature is required for all repetitive transports. 6/11/10