Medicare REQUIRES following information be documented IN THE PCR.

* Reason for the transport
* Explanation as to why the patient requires ambulance transportation and cannot be safely transported by an alternate mode
* Any relevant history provided by patient and/or observers
* A description of patient’s condition and functional status at the time of transfer
* Assessment and clinical evaluations that should include:
	+ Vital signs
	+ Presence of any cardiac issues
	+ Neurological status
	+ Respiratory status
	+ Wound or other skin issues
	+ Amputations
	+ Casts, braces or immobilizers
* Documentation of procedures and supplies provided such as:
	+ Drug therapy
	+ Emergency oxygen administered
	+ IV therapy
	+ Restraints
	+ CPR
	+ Intubation
	+ Cardiac monitoring
* A description of specific monitoring and treatments ordered and performed/administered. The fact that a treatment (i.e., oxygen) or monitoring (i.e., cardiac rhythm monitoring) was performed, absent sufficient description of the patient’s condition (to demonstrate that the treatment and/or monitoring were medically necessary) is inadequate on its own merit to justify payment for the ambulance service.
* The patient’s progress, responses to treatment and changes as treatment is given (e.g., monitoring of vital signs after medication has been given)
* Point of pick-up (e.g., identify place and complete address)
* Mileage associated with transport
* For hospital-to-hospital transports, the trip record must clearly indicate the precise treatment, procedure or medical specialist that is available only at the receiving hospital. Non-specific or vague statements (i.e., needs cardiac care or needs higher level of care) are insufficient.
* Any additional available documentation that supports medical necessity of ambulance transport (e.g., Physician Certification Statement (PCS))
* A separate run sheet for each transport (e.g., two run sheets for round trips)
* For hospital to hospital transports, documentation must indicate the patient was discharged from the origin hospital and admitted to the destination hospital. The specific services that were not available at the first hospital must also be documented.
* Date and legible identity of the observer