Twin Township Ambulance, Inc. PCS Form

Section 1- General Information

Patient Name-_____ **Date of Birth**_____ **Medicare #**_____

Initial Transport Date:_____ **Repetitive Transport Expiration Date (Max 60 Days From Date Signed):**_____

Origin:_____ **Destination:**_____

Section 2- Medical Necessity Questionnaire

Ambulance Transportation is medically necessary only if 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 as that transport by means other than ambulance is contraindicated by the patient's condition.

To be "bed confined" the patient must be : (1) *unable* to get up from bed without assistance; **AND** (2) *unable* to ambulate; **AND** (3) *unable* to sit in a chair or wheelchair (Note: All three of the above conditions must be met in order for the patient to qualify as bed confined)

The following questions must be answered <u>by the medical professional signing below</u> for this form to be valid:

1) Is this patient "bed confined" as defined above? **YES** **NO**
2) Describe the PHYSICAL or MENTAL CONDITION of this patient AT THE TIME OF AMBULANCE TRANSPORTATION that requires the patient to be transported on a stretcher in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

3) Can this patient safely be transported in a wheelchair van (i.e., seated for the duration of the transport, and without a medical attendant?)
   YES **NO**
4) In addition to completing questions 1-3 above, please check any of the following conditions that apply*:
   **Note: supporting documentation for any boxes checked must be maintained in the patient's medical records.*

- o Contractures
- o Danger to self/others
- o Third party assistance/attendant required to apply, administer or regulate or adjust oxygen enroute
- o Restraints (physical or chemical) anticipated or used during transport
- o Patient is confused, combative, lethargic, or comatose
- o Cardiac/hemodynamic monitoring required enroute
- o DVT requires elevation of a lower extremity
- o Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport
- o Unable to maintain erect sitting position in chair for time needed to transport
- o Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
- o Morbid obesity requires additional personnel/equipment to safely handle patient
- o Non-healed fractures
- o Moderate/severe pain on movement
- o IV meds/fluids required
- o Special handling/isolation required

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 other forms 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 that I represent that I have personal knowledge of the patient's condition at the time of transport.

FOR MEDICAID PATIENTS- ONLY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER MAY SIGN
FOR BCBS PATIENTS- ONLY PHYSICIAN MAY SIGN

_____

Signature of Physician or Healthcare Professional Date

_____

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, CNS, PA, NP, or Discharge Planner)

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