



Physician's Certification Statement (PCS)

Non-Emergency Ambulance Transportation

Aetna Ambulance Service, Inc.

PO Box 1150, Manchester, CT 06045-1150

Office Phone: (860) 240-7575

Dispatch Phone: (860) 247-6792

Office Fax: (860) 643-0759

Dispatch Fax: (860) 240-7574

Patient Name: _____ Medicare No.: _____

Patient DOB: _____ Date of Service: _____

Definition of Bed Confined: "Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated. For non-emergency ambulance transport, the following criteria must be met to ensure that ambulance transportation is medically necessary: (1) The Beneficiary is unable to get up from bed without assistance, (2) The Beneficiary is unable to ambulate, and (3) The Beneficiary is unable to sit in a chair or wheelchair." (Medicare Provider Manual)

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 and observation by medically trained personnel is required.

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

The patient is "bed-confined" based on the definition listed in the box above, due to conditions indicated in the narrative below:

- _____
- _____
- Advanced Dementia, late stage Alzheimer's, severe altered mental status, decreased level of consciousness.
 - Frail, debilitated, extreme muscle atrophy, risk of falling out of wheelchair while in motion.
 - Requires administration of oxygen. Liters per minute (LPM): _____
 - Requires airway monitoring during transport.
 - Pt requires (____ EKG monitoring) or (____ IV infusion) during transport.
 - Comatose and requires trained personnel to monitor condition during transport.
 - Seizure prone and requires trained personnel to monitor condition during transport.
 - Medicated and needs trained personnel to monitor condition during transport.
 - Danger to self and/or others; may require restraint. Verbal __, Chemical __, Physical __, Flight Risk __.
 - Suffers from paralysis or contractures. Upper extremities __, Lower extremities __, Fetal ____.
 - Unable to sit for transport without severe pain or risk to recent orthopedic surgery.
 - Has decubitus ulcers (Stage ____, Size ____) and requires wound precautions.
Wound location: Buttocks ____, Sacral ____, Back ____, Hip ____.
 - Requires isolation precautions (VRE, MRSA, C-Diff, etc.) or other special handling during transport.
 - Other (Explain below):

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