WILLARD FIRE DEPARTMENT PHYSICIAN CERTIFICATION STATEMENT

Incident Number

SECTION I – GENERAL INFORMATION

Patient Name: _____ **Transport Date:** (MM/DD/YYYY) _____

Date of Birth: _____ **Medicare #:** _____ **Medicaid #:** _____

From Destination: ☐ Mercy Health Willard Hospital 1100 Neal Zick Rd, Willard, OH 44890 ☐ Blossom Nursing & Rehabilitation 370 E Howard St, Willard, OH 44890 ☐ The Willows at Willard 1050 Neal Zick Rd, Willard, OH 44890 ☐ Other _____

To Destination: ☐ Mercy Health Willard Hospital 1100 Neal Zick Rd, Willard, OH 44890 ☐ Blossom Nursing & Rehabilitation 370 E Howard St, Willard, OH 44890 ☐ The Willows at Willard 1050 Neal Zick Rd, Willard, OH 44890 ☐ Other _____

If using "other" please print facility name or address. (Don't write "home")

Is the patient's stay covered under Medicare Part A (PPS/DRG?) ☐ **YES** ☐ **NO**

Closest appropriate facility? ☐ **YES** ☐ **NO** If **no**, why is transport to more distant facility required? _____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ **YES** ☐ **NO** Describe: _____

SECTION II – 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 that transport by means other than ambulance is contraindicated by the patient's condition.

THE FOLLOWING QUESTIONS MUST BE ANSWERED BY THE MEDICAL PROFESSIONAL SIGNING BELOW FOR THIS FORM TO BE VALID:

1) **Describe the MEDICAL CONDITION** (physical and/or mental) of this patient **AT THE TIME OF AMBULANCE TRANSPORT** that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

_____

2) Is this patient "**bed confined**" as defined below by **MEDICARE Regulations**? ☐ **YES** ☐ **NO**
To be "**bed confined**" the patient must satisfy all three of the following conditions:
(**1**) ***Unable*** to get up from bed without assistance; **AND** (**2**) ***Unable*** to ambulate; **AND** (**3**) ***Unable*** to sit in a chair or wheelchair

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?) ☐ **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*

☐ Moved by stretcher

☐ Patient is confused ☐ Patient is comatose ☐ Patient is combative ☐ Danger to self/other ☐ Need or possible need for restraints

☐ Medical attendant required ☐ Requires oxygen – unable to self administer ☐ IV meds/fluids required ☐ Cardiac monitoring required enroute

☐ Hemodynamic monitoring required enroute ☐ Non-healed fractures ☐ Contractures ☐ Moderate/severe pain on movement

☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds ☐ DVT requires elevation of a lower extremity

☐ Unable to tolerate seated position for time needed to transport ☐ Special handling/isolation/infection control precautions required

☐ Morbid obesity requires additional personnel/equipment to safely handle patient ☐ Physician does not practice at this facility

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify) _____

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

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

Document here: ➡

_____ _____

Signature of Physician* or Healthcare Professional **Date Signed**

_____

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

** **One of the following MUST be documented** **

Physician UPIN # _____

Physician NPI # _____

To locate visit: https://npiregistry.cms.hhs.gov/

Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below**):*

☐ **Physician Assistant** ☐ **Clinical Nurse Specialist** ☐ **Registered Nurse** ☐ **Nurse Practitioner** ☐ **Discharge Planner**

NOTICE: All sections of this form MUST be completed

WILLARD FIRE & RESCUE

Attestation Statement
Physician Certification Statement
Signer Form

Incident # YY/INC#PT#

Transport Date MM/DD/YYYY

Please **PRINT** Patient Information Below

Last Name		Suffix		First		Middle	

Attestation Statement – Authorized Physician Certification Statement PCS Signer

I hereby attest that the Physician Certification Statement (PCS) form dated *(date of service listed above)* accurately reflects signatures/notations that I made in my capacity as *(provider credentials listed below)* when I certified that the above listed Medicare, Medicaid, Private/Commercial Insurance beneficiary required ambulance transport.

I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Authorized Physician Certification Statement (PCS) Signer Signature

X _____ _____ _____

Physician / Practitioner Signature | **Date** | **Physician / Practitioner Printed Name**

Certification Level:

- ☐ MD
- ☐ DO
- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ Clinical Nurse Specialist
- ☐ Registered Nurse
- ☐ Discharge Planner
- ☐ Other _____

NOTICE

This form MUST be completed anytime a Physician Certification Statement (PCS) form is completed.

