Clear Form

B-1c CLINICAL NOTES

• File most recent sheet of this number ON BOTTOM •

DATE
HOSP. NO.
NAME
BIRTHDATE
ADDRESS
SS#
IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. NO., NAME AND LOCATION

PHYSICIAN CERTIFICATION STATEMENT FOR AMBULANCE TRANSFERS

(Regulations require certificate by attending physician for * non-emergency ambulance trips)

Medicare covers ambulance services only if they are furnished to the recipient whose medical condition is such that other means of transportation would be contraindicated. Physician Certification Statement (PCS) must be dated no earlier than 60 days prior to ** the trip. For repeated trips, e.g., renal patients, please list inclusive dates of service. For non-emergency round trips, each trip must be certified.

This is to certify that _____ **Medicare Number** _____
(name of patient)

requires ambulance services on _____ **because he or she:**
(date (s) of trip)

- ☐ requires continuous oxygen and monitoring
- ☐ requires airway monitoring & suctioning
- ☐ requires cardiac monitoring
- ☐ risk of injury to self or others
- ☐ is comatose and requires trained personnel
- ☐ is on a ventilator
- ☐ other

(Explain) _____

- ☐ has decubitus ulcers & requires wound precautions
- ☐ requires isolation precautions
- ☐ is not wheelchair and transfer able
- ☐ is exhibiting signs of decreased level of consciousness
- ☐ patient requires IV maintenance
- ☐ has contractures creating non-ambulatory status
- ☐ is bed confined ***

_____ **(origin of transfer)**

_____ **(destination of transfer)**

_____
(Printed Name of Physician or Authorized Health Care Professional**)**

_____ **(Signature of Physician or Authorized Health Care Professional****)** **(Date Certificate Signed)**

* Scheduled and unscheduled non-emergency transports

** For a resident of a facility, who is under the care of a physician, the statement can be obtained within 48 hours following an unscheduled transport.

*** Regulations define "bed-confined" as: the patient is in bed 100% of the time, is in bed because of a medical condition that precludes either ambulation or wheelchair use, is unable to sit in a chair, is unable to sit or ride in a wheelchair, and the patient cannot be moved by any other means than a stretcher.

**** An Authorized Health Care Professional includes physician assistants, nurse practitioner, and clinical nurse specialists.

Ambulance Service Fax Number: _____