State of Illinois
Department of Healthcare and Family Services

For Non-Emergency Transports Only
Physician Certification Statement (PCS) for Ambulance Transport

FACILITY REPRESENTATIVE - COMPLETE THIS FORM AND PROVIDE IT TO THE APPROPRIATE AMBULANCE SERVICE REPRESENTATIVE

IMPORTANT: A patient is only eligible for ambulance transportation if, at the time of transport, he or she is **unable** to travel **safely** in a personal vehicle, taxi, or wheelchair van. Ambulance transport requests that are for the patient's or requestor's preference, because another provider with the appropriate type of service is not immediately available ***does not meet criteria*** and ***will not be eligible for reimbursement***. Service must be to the nearest available appropriate provider/facility.
All fields on this form are mandatory and must be legible.

PATIENT INFORMATION: Name: _____ Date of Birth: _____

Medicare Beneficiary Identification (MBI) Number: _____ Medicaid Recipient Identification Number (RIN): _____

Commercial Carrier: _____ Policy Number: _____ Insured ID: _____

Patient's Medical Condition supporting transport: _____

TRANSPORT INFORMATION: Type: ☐ Basic Life Support (BLS) ☐ Advanced Life Support (ALS) ☐ Specialty Care Transport (SCT)

REASON: ☐ Appointment ☐ Direct Admit to Hospital ☐ Initial Admit to SNF ☐ Return to Home ☐ Return to SNF ☐ Return after ER Visit

Is this destination the closest appropriate provider/facility? ☐ YES ☐ NO

If no, why is transport beyond the closest appropriate facility? _____

Is this patient's stay covered under Medicare Part A? DRG: ☐ YES ☐ NO PPS: ☐ YES ☐ NO

Is this a transport to another facility for services unavailable at the originating facility? ☐ YES ☐ NO If yes, what service? _____

☐ Services are available at the originating hospital, but inter-hospital transport was requested due to: ☐ Patient Request ☐ Insurance Requirement

ORIGINATING FACILITY (Spell out - no abbreviations):
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DESTINATION (Spell out - no abbreviations):
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

MEDICAL NECESSITY FOR AMBULANCE - COMPLETE ALL THAT APPLY TO PATIENT:

☐ 1. **Is the patient "bed confined"?** To be "bed confined", the patient must be unable to get up from bed without assistance, unable to ambulate and unable to sit in a chair or wheelchair.

☐ **2. Isolation Precautions.** The patient has a diagnosed or suspected communicable disease or hazardous material exposure and must be isolated from the public, or has a medical condition and must be protected from public exposure.

☐ **3. Oxygen.** The patient requires the administration of supplemental oxygen by a third party assistant/attendant, or that the patient requires the regulation or adjustment of oxygen prior to and during transport, and is expected to require the treatment after transport.

☐ **4. Ventilation/Advanced Airway Management.** The patient requires advanced continuous airway management by means of an artificial airway through tracheal intubation (nasotracheal tube, orotracheal tube, or tracheostomy tube) prior to and during transport, and is expected to require the treatment after transport.

☐ **5. Suctioning.** The patient requires suctioning to maintain their airway, or the patient requires assisted ventilation and/or apnea monitoring, prior to and during transport, and is expected to require the treatment after transport.

☐ **6. Intravenous Fluids.** The patient requires the administration of ongoing intravenous fluids prior to and during transport and is expected to require the treatment after transport.

☐ **7. Chemical Restraints or Physical Restraints.**

☐ Chemical Restraints - The patient requires the administration of a chemical restraint during transport, or is under the influence of a previously-administered chemical restraint prior to transport, and the chemical restraint is for the explicit purpose of reducing a patient's functional capacity.

☐ Physical Restraint - The patient requires physical restraints that are required prior to transport and which are maintained for the duration of transport.

☐ **8. One-On-One Supervision.** The patient requires one-on-one supervision due to a condition that places the patient and/or others at a risk of harm for the duration of the transport.
☐ Elopement Risk ☐ Danger to Self or Others ☐ Dementia/Alzheimers with altered mental states

☐ **9. Specialized Monitoring.** The patient requires cardiac and/or respiratory monitoring, or hemodynamic monitoring, prior to, during and after transport.

☐ **10. Special Handling/Positioning.** The patient requires specialized handling for the purpose of positioning during transport due to: ☐ **Decubitus Ulcers on the (location):**
☐ Buttocks ☐ Coccyx ☐ Hip with (stage): ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐ **Contractures:** ☐ Upper Body ☐ Lower Body ☐ Hands

☐ **11. Clinical Observation. The patient requires clinical observation due to:** _____

☐ **12. Unable to maintain a safe sitting position for the length of the time of transport due to:** _____

☐ **13. Stairs / lifting due to:** _____

CERTIFICATION. I certify that the above information is true and correct based on my evaluation of this patient at or just prior to the time of transport, 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), the Illinois Department of Healthcare and Family Services and other payers to support the determination of medical necessity for ambulance services. I also certify that I am a representative of the facility initiating this order and that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another authorized representative, my signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4).

_____ _____ _____
Signature of Licensed Medical Professional Date Signed **Printed Name of Ordering Physician (mandatory)**

_____ Phone Number of Individual Completing Form: _____
Printed Name of Licensed Medical Professional

Ambulance PCS valid for 60 days UNLESS IT IS A HOSPITAL DISCHARGE. Please check appropriate box below for individual completing form.

☐ **Physician - MD/DO** ☐ **Physician Assistant** ☐ **Clinical Nurse Specialist** ☐ **Registered Nurse** ☐ **Nurse Practitioner** ☐ **Discharge Planner** ☐ **LTC Medical Director**
☐ **Licensed Practical Nurse (LPN)** ☐ **Licensed Vocational Nurse (LVN)** ☐ **Social Worker** ☐ **Caseworker**

State of Illinois
Department of Healthcare and Family Services

For Non-Emergency Transports Only
Physician Certification Statement (PCS) for Medicar/Service Car Transport

FACILITY REPRESENTATIVE - COMPLETE THIS FORM AND PROVIDE IT TO THE APPROPRIATE MEDICAR/SERVICE CAR REPRESENTATIVE

IMPORTANT: A patient is only eligible for Medicar/Service Car transportation if, at the time of transport, he or she is **unable** to travel **safely** in a personal vehicle, taxi, or by public transportation.

All fields on this form are mandatory and must be legible.

PATIENT INFORMATION: Name: _____ Date of Birth: _____

Medicaid Recipient Identification Number (RIN): _____

Commercial Carrier: _____ Policy Number: _____ Insured ID: _____

TRANSPORT INFORMATION: Type: ☐ Discharge to Home or Nursing Facility ☐ Direct Admit to Hospital ☐ Appointment

Is this destination the closest appropriate provider? ☐ YES ☐ NO

If no, why is transport beyond the closest appropriate provider? _____

Is this a transport to another facility for services not available at the originating facility? ☐ YES ☐ NO

ORIGINATING FACILITY (Spell out - no abbreviations):
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DESTINATION (Spell out - no abbreviations):
Name: _____
Address: _____
City: _____ State: _____ Zip: _____

If an inter-hospital transfer, is it for: ☐ Higher level of care? ☐ Services not available at the originating hospital? Services needed but not available are:

☐ Cardiac ☐ Trauma ☐ Surgical ☐ Hyperbaric ☐ Burn Unit ☐ Inpatient Dialysis ☐ Inpatient Psychiatric ☐ Stroke Center ☐ Neurology ☐ Pediatrics

☐ No Bed Available ☐ Other (specify): _____

☐ Services are available at the originating hospital, but inter-hospital transport was requested due to: ☐ Patient Request ☐ Insurance Requirement

MEDICAL NECESSITY/CATEGORY OF SERVICE OPTIONS:
CHOOSE ONLY ONE SIDE

CATEGORY OF SERVICE OPTIONS: Please select the most economical category of service that will meet patient's needs:

SERVICE CAR:

☐ Fixed Route Transportation	Public transportation that has an advertised route and schedule. Some examples of Fixed Route transportation include: non-commercial buses, commuter trains, subway trains, and elevated trains.
☐ ADA Paratransit	Curb to curb, shared ride transportation for Americans with Disabilities. Paratransit vehicles include hydraulic or electric lift or ramp and wheelchair lockdowns for patients that can transport independently.
☐ Private Auto, Service Car, Taxi	Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.

MEDICAR/WHEELCHAIR:

☐ Medicar	Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, when the patient's condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc.

Please check all the medical conditions that apply to the patient:

- ☐ Ambulatory - can travel safely using fixed route transportation
- ☐ Ambulatory - does not use a walking device like a walker, cane, etc.
- ☐ Ambulatory - uses walking device like a walker, cane, crutches, etc.
- ☐ Ambulatory - unable to travel by fixed route transportation
- ☐ Uses transfer wheelchair - able to step into a regular car
- ☐ Attendant Needed
- ☐ Wheelchair Bound
- ☐ Unable to step into regular car
- ☐ Attendant Needed
- ☐ Medicar Stretcher Needed

CERTIFICATION. I certify that the above information is true and correct based on my evaluation of this patient at or just prior to the time of transport, and represent that the patient requires transport by a Medicar/Service Car and that other forms of transport are contraindicated. I understand that this information will be used by the Illinois Department of Healthcare and Family Services and other payers to support the determination of medical necessity for Medicar/Service Car services. I also certify that I am a representative of the facility initiating this order and that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another authorized representative, my signature below is made on behalf of the patient.

_____ _____
Signature of Licensed Medical Professional — Date Signed

_____ Phone Number _____
Printed Name of Licensed Medical Professional

**** Medicar/Service Car PCS valid for 180 days UNLESS IT IS A HOSPITAL DISCHARGE. Please check appropriate box below for individual completing form.***

☐ **Physician - MD/DO** ☐ **Physician Assistant** ☐ **Clinical Nurse Specialist** ☐ **Registered Nurse** ☐ **Nurse Practitioner** ☐ **Discharge Planner** ☐ **LTC Medical Director**

☐ **Licensed Practical Nurse (LPN)** ☐ **Licensed Vocational Nurse (LVN)** ☐ **Social Worker** ☐ **Caseworker**