

**Physician's Certification Statement (PCS)**  
*for Non-Emergency Medical Transportation Services*

Initial Transport Date: \_\_\_ / \_\_\_ / \_\_\_      Repetitive Transport Expiration Date (Max 60 Days) \_\_\_ / \_\_\_ / \_\_\_

Patient's Name: \_\_\_\_\_

Medicare #: \_\_\_\_\_ ( )

Ambulance Company Name \_\_\_\_\_

Patient Picked Up At: \_\_\_\_\_

Patient Transported To: \_\_\_\_\_

Physician or Health care Professional's Name: \_\_\_\_\_

**The Medicare definition of Bed-Confinement is: *The inability to get up from bed without assistance; ambulate; and sit in a chair, including a wheelchair.***

**ALL THREE QUESTIONS MUST BE ANSWERED OR THIS PCS WILL BE CONSIDERED INVALID**

1) Is this patient Bed-Confined as defined by Medicare Regulation above?     Yes     No

2) What MEDICAL CONDITION does this patient present ON THE DATE OF AMBULANCE TRANSPORTATION that requires them to be transported on a stretcher in an ambulance:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Can this patient be safely transported by any other means?     Yes     No

**WHEN COMPLETED, SIGN BELOW AND FAX TO NUMBER AT BOTTOM LEFT**

I certify that the above information is true and correct based on my evaluation of this patient, the best of my knowledge and professional training. I understand that this information will be used by the Department of Health and Human Services and Medicare to support the determination of medical necessity for ambulance services.

\_\_\_\_\_  
Signature of Physician or Healthcare Professional

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date Signed

Ute Pass Regional Ambulance District    P.O. Box 149    785 Red Feather Lane    Woodland Park    Colorado    80866

**Fax Completed Form to: 719-687-6410    Questions? Please call 719-687-2291**

**PLEASE FAX OR RETURN THIS PCS WITHIN 48 HOURS**