



ParaBASIC Ambulance Service

"Member of the American Ambulance Association"

"Member of the SC EMS Association"

PH: 843-264-2911 Toll-Free: 1-888-ALS-UNIT Fax: 843-264-2604

Web Address: WWW.PARABASIC.NET Email: PARABASIC@PARABASIC.NET

"When you need an ambulance in an emergency, call 911. For everything else, call ParaBASIC."

Serving Horry, Georgetown, Williamsburg, Berkeley and Charleston Counties

Physician Certification Statement (PCS) for Ambulance Transportation

SECTION I – GENERAL INFORMATION

Patient's Name _____ Dates of Service ____/____/____ to ____/____/____ (max 60 days)

Medicare # _____ Other Insurance _____ Policy# _____

Transported From _____ Transported To _____

SECTION II – Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed confined, and it is documented that the beneficiary's condition is such that other means of transport are contraindicated: OR, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically necessary and required.

Check all that apply:

- Bed Confined * All three below must be met to qualify for bed confinement
 - Unable to ambulate*
 - Unable to get out of bed without assistance*
 - Unable to safely sit up in a wheelchair*
- Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning
- Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- Oxygen required to be applied, administer or adjusted by third party assistance/attendant
- IV medications/fluids required during transport
- Cardiac/Hemodynamic monitoring required during transport
- Special Handling en route – Isolation

- Paralysis (partial or total)
- Contractures
- Non-healed fractures or wounds
- Moderate to severe pain on movement
- DVT requires elevation of lower extremity
- Orthopedic device (backboard, halo, use of pins in traction, etc) requiring special handling en route
- Severe muscular weakness and de-conditioned state precludes any significant physical activity

- Restraints (physical or chemical) anticipated or used during transport
- Danger to self or others – monitoring, seclusion (flight risk)
- Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- Confused, combative, lethargic, comatose

Describe the medical condition of this patient that requires ambulance transport and why transport by other means are contraindicated: _____

***Hospitals and SNF:** What services does this patient need that are available at a second facility but are not available at the closest facility? _____

SECTION III – PHYSICIAN'S AUTHORIZATION or other Healthcare Professional

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service and that the patient requires ambulance transport for the reasons documented on this form.

Signature of Attending Physician	Physician Printed Name	Date
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This authorization must be completed and signed by the attending physician for scheduled repetitive transports. For unscheduled or scheduled non-repetitive transports this authorization may be signed by the attending physician, physician assistant, clinical nurse specialist, nurse practitioner, registered nurse or discharge planner employed by the facility where the beneficiary is being treated and who has personal knowledge of the beneficiary's condition.