LIFEGUARD AMBULANCE SERVICE

PHYSICIAN CERTIFICATION STATEMENT (PCS)

REPETITIVE NON-EMERGENCY AMBULANCE TRANSPORT

Patient Name:_______________________ DOB:_______________ HIC/Medicare #: ________________

Physician Name:_____________________________ Phone:__________________ Fax:_____________

Pick-Up location: ____________________________________ Pick-Up Room: _____________________

Destination: ____ Dest. Room: _______________________

The section below must be completed by the patient's attending physician or authorized designee.

LGA Personnel may NOT complete this section.

Mark all reasons why the patient requires non-emergency ambulance services.

□ **Patient unable to sit safely in a wheelchair while vehicle in motion DUE TO:**

____

□ **Patient requires monitoring/treatment during transport:** (check all applicable items below)

- □ **Ventilator** dependent
- □ **IV** medications required en route
- □ **ECG** monitoring required en route
- □ **Oxygen assistance** required en route
- □ **Suctioning /airway control** required en route

□ **Psychiatric Hold** □ **Requires Restraints** □ **Flight Risk**

□ **Isolation Precautions** due to:____

□ **Special Positioning or Handling required** preventing transport by wheelchair or other means: (describe positioning or handling necessary)

____

□ **Other:** (explain below)

____

I certify I am familiar with the patient's condition and have determined the patient's medical record supports ambulance transportation for the reason(s) specified above. Ambulance service is hereby ordered.

Only a physician may sign this Repetitive Patient PCS form.
Failure to provide a date at the time of signature will make this form invalid.

____

Print Name	Signature	Date

Physician Certification Statement Pursuant to CFR [Section 410.40 (d) (2-3)]
Medicare Part B benefits are payable for ambulance services only when the use of any other method of transportation is contraindicated by the patient's condition. The Centers for Medicare and Medicaid Services requires documentation of the medical necessity for