PCS Form Quick Guide

for healthcare partners of

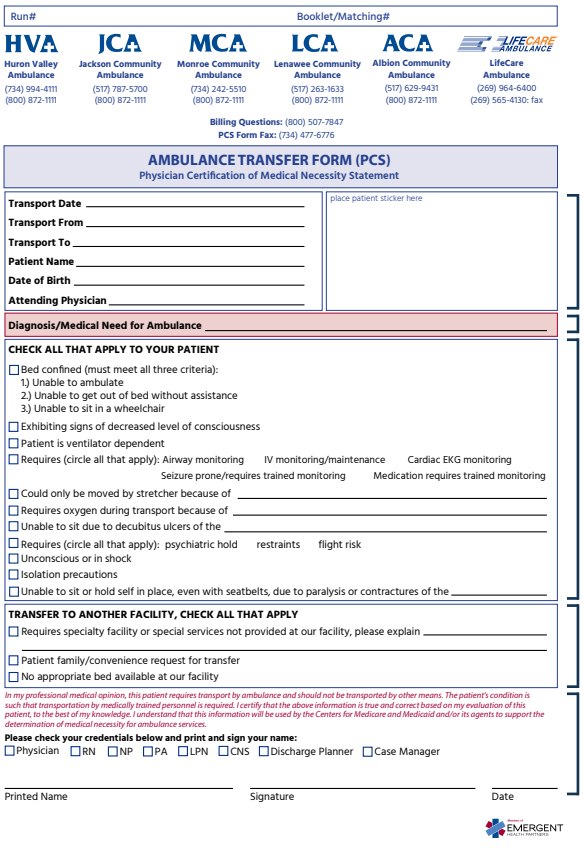
HVA · JCA · MCA · LCA · ACA · LIFECARE AMBULANCE

Members of EMERGENT HEALTH PARTNERS

This reference sheet outlines the steps to correctly complete Emergent Health Partners' PCS form.

A digital version of the form can be found on our website:

www.emergenthealth.org/pcs-forms



Run# Booklet/Matching#

HVA	JCA	MCA	LCA	ACA	LIFECARE AMBULANCE
Huron Valley Ambulance	Jackson Community Ambulance	Monroe Community Ambulance	Lenawee Community Ambulance	Albion Community Ambulance	LifeCare Ambulance
(734) 994-4111	(517) 787-5700	(734) 242-5510	(517) 263-1633	(517) 629-9431	(269) 964-6400
(800) 872-1111	(800) 872-1111	(800) 872-1111	(800) 872-1111	(800) 872-1111	(269) 565-4130: fax

Billing Questions: (800) 507-7847
PCS Form Fax: (734) 477-6776

AMBULANCE TRANSFER FORM (PCS)
Physician Certification of Medical Necessity Statement

Transport Date _____
Transport From _____
Transport To _____
Patient Name _____
Date of Birth _____
Attending Physician _____

place patient sticker here

Section 1

Diagnosis/Medical Need for Ambulance _____

Section 2

CHECK ALL THAT APPLY TO YOUR PATIENT

☐ Bed confined (must meet all three criteria):
1.) Unable to ambulate
2.) Unable to get out of bed without assistance
3.) Unable to sit in a wheelchair
☐ Exhibiting signs of decreased level of consciousness
☐ Patient is ventilator dependent
☐ Requires (circle all that apply): Airway monitoring IV monitoring/maintenance Cardiac EKG monitoring Seizure prone/requires trained monitoring Medication requires trained monitoring
☐ Could only be moved by stretcher because of _____
☐ Requires oxygen during transport because of _____
☐ Unable to sit due to decubitus ulcers of the _____
☐ Requires (circle all that apply): psychiatric hold restraints flight risk
☐ Unconscious or in shock
☐ Isolation precautions
☐ Unable to sit or hold self in place, even with seatbelts, due to paralysis or contractures of the _____

Section 3

TRANSFER TO ANOTHER FACILITY, CHECK ALL THAT APPLY

☐ Requires specialty facility or special services not provided at our facility, please explain _____
☐ Patient family/convenience request for transfer
☐ No appropriate bed available at our facility

Section 4

In my professional medical opinion, this patient requires transport by ambulance and should not be transported by other means. The patient's condition is such that transportation by medically trained personnel is required. I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge. I understand that this information will be used by the Centers for Medicare and Medicaid and/or its agents to support the determination of medical necessity for ambulance services.

Please check your credentials below and print and sign your name:
☐ Physician ☐ RN ☐ NP ☐ PA ☐ LPN ☐ CNS ☐ Discharge Planner ☐ Case Manager

Printed Name _____ Signature _____ Date _____

Section 5

EMERGENT HEALTH PARTNERS

Section 1: Transport Details

Accurately complete all six components:

1. Transport date
2. Origin of transport
3. Destination of transport
4. Patient name
5. Patient DOB
6. Name of attending physician

Patient stickers with all/some of the information can be used

Section 2: Identify the "what"

What are the current diagnoses or medical conditions that necessitate stretcher transportation?

Section 3: Identify the "why"

- Why must the patient go by stretcher transportation?
- Include details of the patient's current condition that prove the patient cannot be safely transported by other means and/or requires monitoring by EMS personnel.

Section 4: Transfer to another facility

- This section is only required if one of the three scenarios outlined on the form are applicable. Please select a box and complete.
- If nothing applies in section 3, then section 4 is required.

Section 5: Certify

Certify the PCS by completing all four components:

1. Check credentials box
2. Print name
3. Sign name
4. Date

Questions or need assistance? Contact us:

Jennifer Welser, Billing Coordinator

Phone: 734-477-6548

Main Billing Phone: 800-507-7847

Fax: 734-477-6776

Email: billinginfo@emergenthealth.org

Updated June 2021

See back for additional information

PCS Form Quick Guide

for healthcare partners of

HVA · JCA · MCA · LCA · ACA · LIFECARE AMBULANCE

Members of EMERGENT HEALTH PARTNERS

Additional PCS Form Information

Emergent Health's PCS Form

- When using Emergent Health's PCS form, sections 1, 2 and 5, as well as sections 3 and/or 4, are required.
- See page one of the PCS Form Quick Guide for reference.
- Each section must be accurately filled out in its entirety.
- **If none of the boxes in Section 3 apply to the patient, then Section 4 must be completed in addition to required sections 1, 2, and 5.**

Other PCS Forms

There are various versions of PCS forms that exist. ***Emergent Health will accept any version of the form if the following information is included:***

- Identification of patient (name, DOB)
- Identification of patient's attending physician
- Date of service
- Origin and destination of transport
- Diagnosis or medical need for ambulance
- Support of the diagnosis or medical need for ambulance with clinical assessments or data
- Name, credentials, and dated signature of person certifying the PCS form
    - **Please note:** only a physician, RN, NP, PA, LPN, CNS, Discharge Planner, or Case Manager are authorized to certify a PCS form. EMS providers are not permitted to fill out any portion of a PCS form. It is the responsibility of the attending physician or authorized delegate.