Run#	Booklet/Matching#

HVA Huron Valley Ambulance
(734) 994-1111
(800) 872-1111

JCA Jackson Community Ambulance
(517) 787-5700
(800) 872-1111

MCA Monroe Community Ambulance
(734) 242-5510
(800) 872-1111

LCA Lenawee Community Ambulance
(517) 263-1633
(800) 872-1111

ACA Albion Community Ambulance
(517) 629-9431
(800) 872-1111

LifeCare Ambulance
(269) 964-6400
(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

Diagnosis/Medical Need for Ambulance _____

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 _____

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

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 _____