KOOTENAI COUNTY EMS SYSTEM

Physician Certification Statement (PCS)

Patient's Last Name:	First:	M.I.
SS#:	Date of Birth:	
Date of Transport:	Referring Physician:	
Sending Facility:	Receiving Physician:	
Destination:		

Instructions
This form must be completed and signed by the referring provider or designee prior to any KCEMSS transport.
Form may be faxed to: (208) 930-4259

Is the patients stay covered under Medicare Part A (PPS/DRG?) ☐ Yes ☐ No

Closest appropriate facility? ☐ Yes ☐ No If no, why is transport to more distant facility required?

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility:

Has Pre Authorization from insurance been obtained? ☐ Yes ☐ No Pre Authorization #

Primary Diagnosis: Secondary Diagnosis:

☐ Hospital to Hospital Transport ☐ Hospital to SNF or Residence

➔ Transports due to lack of resources including, but not limited to stretcher van, taxi wheelchair van, bariatric wheelchair or stretcher services may not be covered by Medicare, Medicaid or other insurance.

Describe the medical condition (physical and/or mental) of this patient at the time of transport that requires the patient to be medically observed, treated and transported by a licensed medical transport team via ambulance.

_____

_____

_____

Patient requires Critical Care Services during transport? ☐ Yes ☐ No If YES, what service does the patient require?

☐ Hospice Related Transport:

Is patient in hospice benefit at time of transport and transport is related to hospice illness? ☐ Yes ☐ No

If YES, Hospice will be billed for transport services. Patient is assigned to _____ Hospice.

If NO, patient will need to meet medical necessity.

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance due to the reason documented on this form. I understand that this information will be used by the Centers of Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and that I have personal knowledge of the patient's condition at the time of transport.

_____
Printed Name of Signer below (required):

_____ _____
Signature: Date:

☐ Attending Physician (required for repetitive transports – expires 60 days from date signed)
☐ RN ☐ Discharge Planner ☐ Nurse Practitioner ☐ Physician Assistant

To provide exceptional, compassionate and innovative medical care and service to the citizens and visitors of Kootenai County.