PLEASE COMPLETE THIS FORM FOR ALL NON-EMERGENCY **AMBULANCE** TRANSPORTS.
PLEASE ATTACH A PATIENT DEMOGRAPHIC SHEET (FACE SHEET) TO THIS FORM FOR THE AMBULANCE PERSONNEL.

IF YOU ARE ORDERING A WHEELCHAIR VAN TRANSPORTATION, PLEASE COMPLETE AN ***ODHS 3452*** FORM FOR THE WHEELCHAIR VAN ATTENDANT.
ADDITIONAL FORMS CAN BE OBTAINED BY CALLING OUR BUSINESS OFFICE.

PRACTITIONER CERTIFICATION STATEMENT (PCS)

DATE OF SERVICE ______________ TIME OF PICK-UP ______________

PATIENT'S NAME ____

IF NO FACE SHEET ATTACHED, PLEASE COMPLETE THE FOLLOWING INFORMATION:

DOB ______________________ SOC SEC # ______________

MEDICARE ______________________ MEDICAID ______________

OTHER INSURANCE: NAME ______________________________
POLICY # ______________________________
CLAIM MAILING ADDRESS ______________________________

PATIENT'S BILLING ADDRESS: ______________________________

PATIENT'S PHONE NUMBER: ______________________________

ORIGIN: ____

DESTINATION: ____

IF GOING FOR OUTPATIENT SERVICES, STATE WHAT TYPE OF SERVICES OR PROCEDURE PATIENT IS GOING FOR. ______________________________

IF PATIENT RESIDES IN AN SNF, IS PATIENT IN THEIR MEDICARE PART A STAY? ______________

IF THIS IS A HOSPITAL TO HOSPITAL TRANSPORT, STATE WHY PATIENT IS BEING DISCHARGED FROM 1ST HOSPITAL AND ADMITTED TO 2ND ______________________________

CHIEF DX RELATED TO THIS TRANSPORT ______________________________

STATE CONDITION OF PATIENT AND REASON WHY AMBULANCE IS REQUIRED (BE SPECIFIC AND EXPLAIN WHY PATIENT CAN NOT TRAVEL BY WHEELCHAIR OR OTHER COMMON CARRIER)

____

PLEASE CHECK ALL APPLICABLE LINES

_____ Patient is bedconfined.
_____ Patient requires restraints.
_____ Patient is unconscious or in shock.
_____ Patient requires oxygen and can not administer their own. *
_____ Patient requires IV or EKG monitoring enroute.
_____ Patient has to remain immobile due to fracture or suspected fracture.
_____ Patient is contracted or in fetal position.
_____ Patient sustained a stroke or myocardial infarction.
_____ Patient could be moved only by stretcher. *
_____ Patient is wheelchair bound.

*Must be specific as to why patient could not administer own oxygen or why patient could be moved only by stretcher. ______________________________

ADDITIONAL COMMENTS: ______________________________

In my professional opinion the ambulance service rendered to the above patient on the above date of service was medically necessary due to the conditions listed above, and any other means of transport would be hazardous to the patient's health and safety.

A signature from one of the following practitioners is required; Physician, PA, NP, CNS, RN, or Discharge Planner who is employed by the hospital or facility where the patient is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished.

Practitioner's Name (Please Print) ______________________________

Practitioner's Signature ______________________________

Date Signed ______________________

PHYSICIANS Medical Transport Team
4495 Cranwood Parkway • Warrensville Heights, Ohio 44128
Dispatch 216-454-4911
Fax Number 216-332-1669