MEDICAL NECESSITY CERTIFICATION STATEMENT (PCS) REPETITIVE

Please *FAX* completed form to (989) 752-6803
***MAIL* the original form to:**
Mobile Medical Response
4305 State Street
Saginaw, MI 48603

To schedule a transport or for assistance, please call
(989) 907-2020 or (866) 781-3218

MMR MOBILE MEDICAL RESPONSE

SECTION I – GENERAL INFORMATION

1) Patient's Name:_____ Date of Birth: _____
2) Transport From: _____Transport To: _____
3) Transport Date:_____ Patient's Medicaid# _____(If Applicable)
4) Type of transport and frequency: _____
5) Attending Physician: _____

SECTION II - MEDICAL NECESSITY

1) ***Medical Condition/Diagnosis That Requires ONGOING Ambulance Transport***: _____

_____

2) ***Bed Confined***? **YES** or **NO** *(Circle One)*

Bed Confined Definition-must meet all criteria: *Inability to get up from bed without assistance, ambulate and sit in a chair, including a wheelchair, per CMS rules.*

3) ***Please Check All Required That Apply*:**

__ Airway Compromise-Suction
__ Confusion
__ Isolation Precautions
__ Paralysis (hemi, semi, quad)
__ Should not stand/pivot/ambulate
__ Morbid Obesity
__ Unable to sit in a wheelchair due to decubitus ulcers or other wounds
__ Unable to tolerate a seated position during transport
__ Other (specify) _____

__ Cardiac Monitoring
__ Contractures
__ IV Maintenance
__ Non-healed fractures
__ Restraints
__ Vent dependent

__ Comatose
__ Danger to self/others
___Moderate/severe pain on movement
__ Oxygen monitored by trained staff
__ Oxygen self-monitored
__ Psychiatric care
__ Monitored by trained staff for_____.

4) What services are required at receiving facility that **CAN NOT** be provided at the sending facility?

_____

5) Closest facility? **YES** or **NO** If **NO**, why is transport to more distant facility required? *(Circle One)*

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; and that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

☐ **If this box is checked, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows:** _____

_____

Name: _____ **Credential: MD / DO (circle)**

Sign Name: _____ **Date Signed** _____

Physician NPI Number:_____

Who can sign REPETITIVE PCS Form: Only a **PHYSICIAN** can sign for REPETITIVE patients.

A REPETITIVE PCS for **Medicaid** patients is only valid for **30 days**, all others are valid for 60 days