Certification for Non-Emergency Ambulance (PCS)

LOYOLA MEDICINE TRANSPORT
905 West North Avenue
Melrose Park, IL 60160
Main 708-538-5307
Fax 708-538-5340

IMPORTANT: **A patient is *only* eligible for ambulance transportation if**, at the time of discharge, he or she is ***unable*** to travel ***safely*** in a personal vehicle, taxi, or wheelchair van. Ambulance transport requests that are the ***patient's preference***, or because assistance is needed at the discharging hospital or at home (to navigate stairs and/or to assist or lift the patient), and/or because another provider with the appropriate level or service is not immediately available ***do not meet criteria*** and ***will not be eligible for reimbursement***. Transportation must be to the nearest available appropriate provider.

1. Patient Information — *Only MCA forms that have the Recipient ID can be processed. If Medicaid is pending, please complete this form and give a copy to the transportation provider but do not submit it to First Transit.*

Medicaid Recipient ID Number (RIN)

Patient's Name | Date of Birth

2. Trip Information | Date of Trip | Pickup Time | Reason for Trip: Hospital Discharge

3. Pickup | Location Name *(no abbreviations)*

Address

City

County | State | ZIP

4. Destination | Location Name *(no abbreviations)*

Address

City

County | State | ZIP

5.Transportation | Name of Transportation Provider | Phone Number of Transportation Provider

Please choose type of Ambulance Transport (only one box) : ☐ Basic Life Support (BLS) ☐ Advanced Life Support (ALS) ☐ Critical Care Transport (CCT) ☐ *(Optional)* Oxygen Required, (Not self-administered)

6. Reason why patient needs ambulance transport. Complete A and B.

A. Choose one or more criteria boxes

☐ **1. Isolation Precautions**. The patient has a diagnosed or suspected communicable disease or hazardous material exposure and must be isolated from the public, or has a medical condition and must be protected from public exposure.

☐ **2. Oxygen.** The patient requires the administration of supplemental oxygen by a third party assistant/attendant, or that the patient requires the regulation or adjustment of oxygen prior to and during transport, and is expected to require the treatment after transport

☐ **3. Ventilation/Advanced Airway Management.** The patient requires advanced continuous airway management by means of an artificial airway through tracheal intubation (nasotracheal tube, orotracheal tube, or tracheostomy tube) prior to and during transport, and is expected to require the treatment after transport.

☐ **4. Suctioning.** The patient requires suctioning to maintain their airway, or that the patient requires assisted ventilation and/or apnea monitoring, prior to and during transport, and is expected to require the treatment after transport.

☐ **5. Intravenous Fluids.** The patient requires the administration of ongoing intravenous fluids prior to and during transport and is expected to require the treatment after transport.

☐ **6. Chemical Restraints.** The patient requires administration of a chemical restraint during transport, or is under the influence of a previously-administered chemical restraint prior to transport, and that the chemical restraint is for the explicit purpose of reducing a patient's functional capacity. The medication shall be ordered and **documented in the medical record.**

☐ **7. Physical Restraint.** The patient requires physical restraints that are required prior to transport and which are maintained for the duration of transport.

☐ **8. One-On-One Supervision.** The patient requires one-on-one supervision due to a condition that places the patient and/or others at a risk of harm or elopement for the duration of the transport.

☐ **9. Specialized Monitoring.** The patient requires cardiac and/or respiratory monitoring, or hemodynamic monitoring, prior to, during and after transport.

☐ **10. Special Handling/Positioning.** The patient requires specialized handling for the purpose of positioning during transport.

☐ **11. Clinical Observation.** The patient requires clinical observation from one environment with 24-hour clinical observation or treatment provided by certified or licensed nursing personnel to another environment with 24-hour clinical observation or treatment provided by certified or licensed nursing personnel. This criterion is not satisfied based solely on the type of hospital or other facility from which the patient is being transferred from or to.

B. Based on criteria selected in Section A, detail the specific procedures, conditions, diagnosis, monitoring, medications, special handling, etc. that are required prior to, during and expected to continue after transport.

7. List patient's medical diagnosis that supports criteria at time of discharge.

8. Certification and Attestation *(you must select either A, B, or C)*

☐ **A. (For completion by physician)** The patient meets the HFS criteria for non-emergency ambulance service.

☐ **B. (For use by designee)** I have conferred with the physician or other authorized provider as set forth below, whose determination is that the patient meets the HFS criteria for non-emergency ambulance service.

☐ **C.** (For completion by physician) The patient does not meet the HFS criteria for non-emergency ambulance transportation. Following is my justification for ordering non-emergency ambulance transportation. This form does not constitute prior approval if this box is checked.

Certification: I certify that the information in this document supplied for the patient criteria certification constitutes true, accurate and complete information and is supported in the medical record of the patient . I understand that the Information I am supplying for the patient criteria will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and / or state law, which can result in fines, civil monetary penalties or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

Name of Physician (MD, DO, PA or APN) authorizing non-emergency ambulance | Phone Number of Physician | Return Fax Number in case MCA needs revision

Name of Designee (RN, LCSW, NP or Discharge Planner) | Phone Number of Designee | Email (optional)

Hospital's NPI # | Signature (Typed name of Physician or Designee constitutes electronic signature) | Date Signed