

Physician Certification Statement (PCS) Form

Patient/Member Information			
Full Name:	SCFHP ID:		
DOB: Month Day Year	Phone Number:		
Address:	City:	State:	Zip:
Mode Of Transportation Needed			
<input type="checkbox"/> Non-Medical Transportation (NMT) Non-Medical Transportation is travel by bus, passenger car, taxicab or other forms of public or private conveyance. A PCS form is not required. Member may contact Customer Service to arrange ride.			
<input type="checkbox"/> Non-Emergency Medical Transportation (NEMT) Non-Emergency Medical Transportation is available to obtain medically necessary services when the patient's medical/physical condition does not allow them to travel by bus, passenger car, taxicab or other forms of public or private conveyance. Please check all applicable modalities, multiple modalities may be requested: <ul style="list-style-type: none"> <input type="checkbox"/> Ambulance (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Transfer between facilities that requires continuous intravenous medication, medical monitoring, or observation <input type="checkbox"/> Transfer from an acute care facilities to another acute care facility <input type="checkbox"/> Transport for member who has recently been placed on oxygen (does not apply to members who carry their own oxygen for continuous use) <input type="checkbox"/> Chronic conditions requiring oxygen and medical monitoring <input type="checkbox"/> Litter/Gurney Van (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Requires prone or supine position; incapable of sitting for the period of time needed to transport, and requires specialized safety equipment over and above what is normally available in passenger cars, taxicabs, or other forms of public transportation <input type="checkbox"/> Post-operative, stable members who cannot tolerate sitting upright for the time required for transport from pick-up point to destination <input type="checkbox"/> Bed Bound <input type="checkbox"/> Spica cast <input type="checkbox"/> Wheelchair Van (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Requires wheelchair or assistance to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation <input type="checkbox"/> Severe mental confusion <input type="checkbox"/> Paraplegia <input type="checkbox"/> Dialysis recipient <input type="checkbox"/> Chronic conditions requiring oxygen, but do not require monitoring <input type="checkbox"/> Air Transport 			

Diagnosis (Must support the need for Non-Emergency Medical Transportation)**Diagnosis:****ICD 10 Code(s):****Function Limitations Justification** (Required)

Please document the patient's limitations and provide specific physical and medical limitations that preclude the patient's ability to reasonably ambulate with assistance or be transported by public or private vehicles.

Date(s) of Service Needed: One-Time Only

Date:

 Ongoing (up to 12 months)

Start Date:

End Date:

Certified By:

I, the member's physician, dentist, podiatrist or mental health or substance use disorder provider responsible for providing medical care to the member, certify that medical necessity was used to determine the type of transportation requested.

Physician/Provider's Name:

Physician/Provider's Signature

Date:

NPI:

Phone Number:

Fax Number: