Transport PCR Documentation

TRAINING DEPARTMENT

Transport Calls

- Non-emergency patient transfers (home, hospital, nursing facility, interfacility).
- Treat every transport with the same professionalism as a 911 response.
- Complete a full patient assessment as you would for a 911 call.

Required Physical Documents

Before leaving, obtain BOTH:

- Physician Certification of Necessity (PCN)
- Face Sheet

Make sure the forms have all the following relevant information. Lack of these means they get rejected for payment by Insurance and it takes many months and Tony many trips to resolve.

PCN Checklist	Face Sheet
✓ Signed by physician ✓ At least two medical necessity boxes checked ✓ States why ambulance transport is medically necessary ✓ "Ardsley Secor Volunteer Ambulance Corps for this Transport" marked "Yes"	Includes patient demographics, DOB, insurance, and identifying information.

PCR Narrative Must Include

- Assessment findings
- Transport details
- Receiving staff
- Medical necessity from the PCN at the end of the narrative.
- Upload the PCN and Face Sheet to the PCR and label each attachment clearly.

After the Call

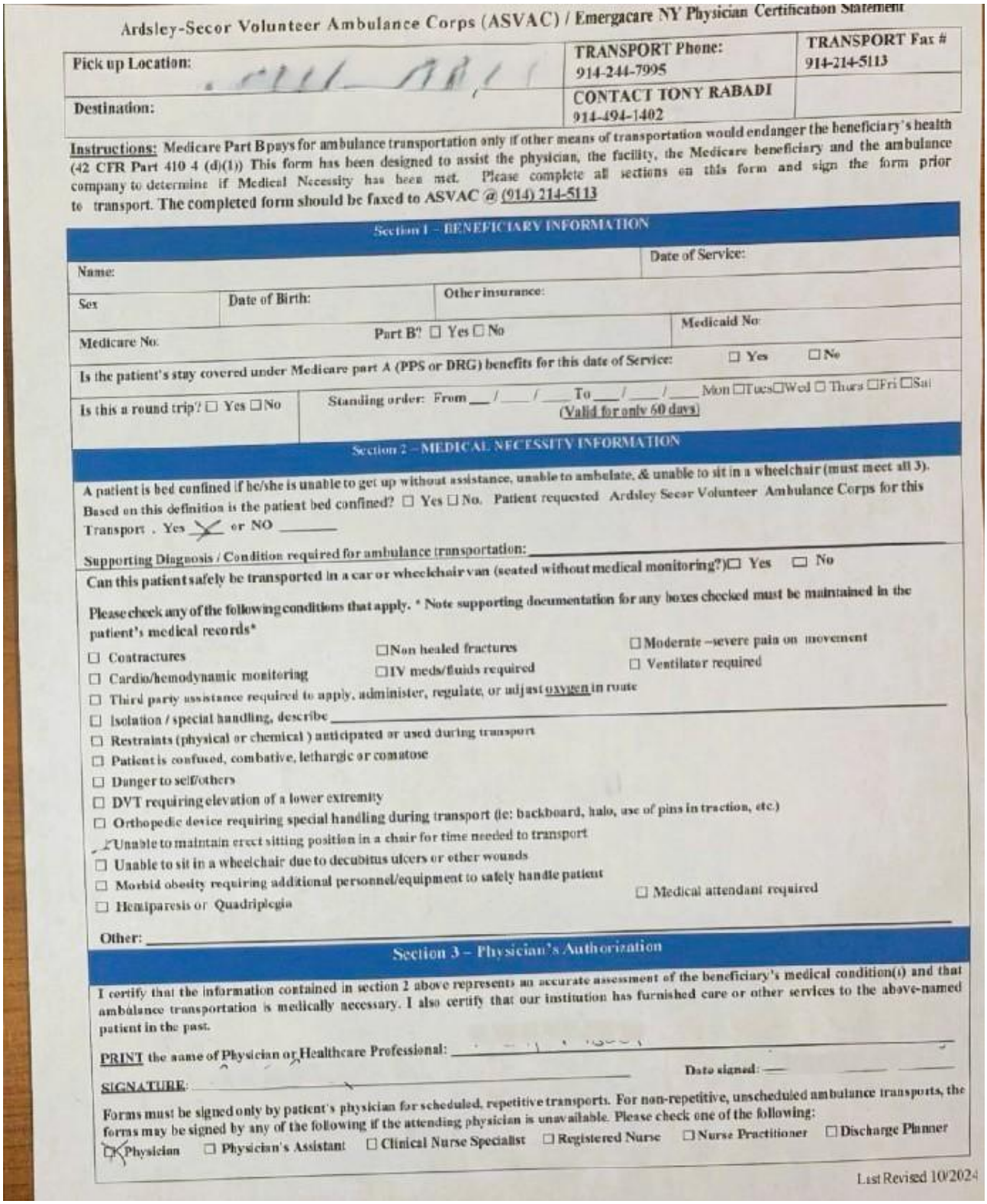
Place the original PCN and Face Sheet in the black bin in the back office.

Attachments:

1. Physician Certification of Necessity (PCN)
2. Face Sheet

Transport PCR Documentation

Attachment 1: Physician Certification of Necessity (PCN)



Ardsley-Secor Volunteer Ambulance Corps (ASVAC) / Emergacare NY Physician Certification Statement

Pick up Location:	TRANSPORT Phone: 914-244-7995	TRANSPORT Fax # 914-214-5113
Destination:	CONTACT TONY RABADI 914-494-1402	

Instructions: Medicare Part B pays for ambulance transportation only if other means of transportation would endanger the beneficiary's health (42 CFR Part 410 4 (d)(1)) This form has been designed to assist the physician, the facility, the Medicare beneficiary and the ambulance company to determine if Medical Necessity has been met. Please complete all sections on this form and sign the form prior to transport. The completed form should be faxed to ASVAC @ (914) 214-5113

Section 1 – BENEFICIARY INFORMATION

Name: Date of Service:

Sex | Date of Birth: | Other insurance:

Medicare No: Part B? ☐ Yes ☐ No | Medicaid No:

Is the patient's stay covered under Medicare part A (PPS or DRG) benefits for this date of Service: ☐ Yes ☐ No

Is this a round trip? ☐ Yes ☐ No | Standing order: From ___/___/___ To ___/___/___ Mon ☐Tues ☐Wed ☐ Thurs ☐Fri ☐Sat (Valid for only 60 days)

Section 2 – MEDICAL NECESSITY INFORMATION

A patient is bed confined if he/she is unable to get up without assistance, unable to ambulate, & unable to sit in a wheelchair (must meet all 3). Based on this definition is the patient bed confined? ☐ Yes ☐ No. Patient requested Ardsley Secor Volunteer Ambulance Corps for this Transport . Yes X or NO _____

Supporting Diagnosis / Condition required for ambulance transportation: _____

Can this patient safely be transported in a car or wheelchair van (seated without medical monitoring?) ☐ Yes ☐ No

Please check any of the following conditions that apply. * Note supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non healed fractures ☐ Moderate –severe pain on movement
☐ Cardio/hemodynamic monitoring ☐ IV meds/fluids required ☐ Ventilator required
☐ Third party assistance required to apply, administer, regulate, or adjust oxygen in route
☐ Isolation / special handling, describe _____
☐ Restraints (physical or chemical) anticipated or used during transport
☐ Patient is confused, combative, lethargic or comatose
☐ Danger to self/others
☐ DVT requiring elevation of a lower extremity
☐ Orthopedic device requiring special handling during transport (ie: backboard, halo, use of pins in traction, etc.)
☐ Unable to maintain erect sitting position in a chair for time needed to transport
☐ Unable to sit in a wheelchair due to decubitus ulcers or other wounds
☐ Morbid obesity requiring additional personnel/equipment to safely handle patient
☐ Hemiparesis or Quadriplegia ☐ Medical attendant required

Other: _____

Section 3 – Physician's Authorization

I certify that the information contained in section 2 above represents an accurate assessment of the beneficiary's medical condition(s) and that ambulance transportation is medically necessary. I also certify that our institution has furnished care or other services to the above-named patient in the past.

PRINT the name of Physician or Healthcare Professional: _____

SIGNATURE: _____ Date signed: ___/___/___

Forms must be signed only by patient's physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, the forms may be signed by any of the following if the attending physician is unavailable. Please check one of the following:

☐ Physician ☐ Physician's Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner

Last Revised 10/2024

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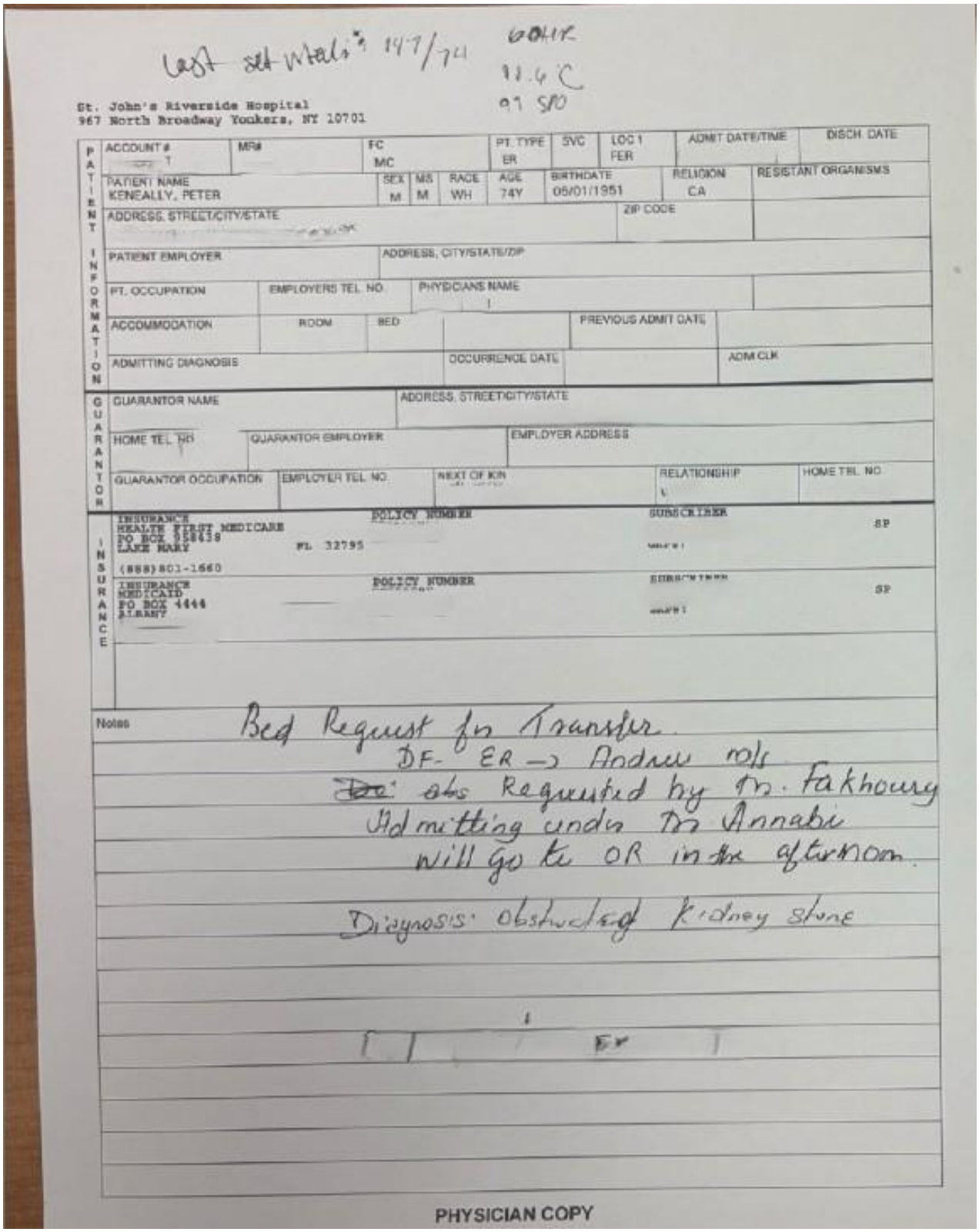
Attachment 2: Face Sheet



Left 3rd Weds 147/74 60HR 11.4°C 97 SPO

St. John's Riverside Hospital
967 North Broadway Yonkers, NY 10701

PATIENT INFORMATION

ACCOUNT #	MR#	FC	PT. TYPE	SVC	LOC 1	ADMIT DATE/TIME	DISCH. DATE
		MC	ER		FER		

PATIENT NAME	SEX	MS	RACE	AGE	BIRTHDATE	RELIGION	RESISTANT ORGANISMS
KENEALLY, PETER	M	M	WH	74Y	05/01/1951	CA	

ADDRESS, STREET/CITY/STATE	ZIP CODE

PATIENT EMPLOYER	ADDRESS, CITY/STATE/ZIP

PT. OCCUPATION	EMPLOYERS TEL NO.	PHYSICIANS NAME

ACCOMMODATION	ROOM	BED		PREVIOUS ADMIT DATE

ADMITTING DIAGNOSIS	OCCURRENCE DATE	ADM CLK

GUARANTOR

GUARANTOR NAME	ADDRESS, STREET/CITY/STATE

HOME TEL NO	GUARANTOR EMPLOYER	EMPLOYER ADDRESS

GUARANTOR OCCUPATION	EMPLOYER TEL NO.	NEXT OF KIN	RELATIONSHIP	HOME TEL NO
			L	

INSURANCE

	POLICY NUMBER	SUBSCRIBER	SP
INSURANCE HEALTH FIRST MEDICARE PO BOX 958438 LAKE MARY FL 32795 (888)801-1660			
INSURANCE MEDICAID PO BOX 4444 ALBANY	POLICY NUMBER	SUBSCRIBER	SP

Notes

Bed Request for Transfer.
DF- ER → Andrew RDS
~~Dr~~ obs Requested by Dr. Fakhoury
Admitting under Dr Annabi
will go to OR in the afternoon.

Diagnosis: obstructed kidney stone

ER

PHYSICIAN COPY