Physician Certification Statement (PCS) for NEMT

Step #1: Fill out this form in cclink or the CCHP Provider Portal (NEMT Referral).
Step #2: Submit the referral in ccLINK or the CCHP provider portal. **DO NOT FAX THIS TO CCHP.**
Step #3: Contact CCHP at 1(877)800-7423 (Press 3) to schedule NEMT.

Section 1 – Patient Information

Last Name:	First Name:	Date of Birth:

Section 2 – Transport Information

Start Date	End Date:	From:	To:

If outside of Contra Costa County, why is transport to a more distant facility needed?

Section 3 – Medical Necessity Information

Medical necessity is established when the patient's condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care. In other words, no other transportation type could be used without endangering the patient's health. If the patient can be transported by any other means (e.g. car, taxi, etc.) then medical necessity for NEMT does not exist.

If patient <u>does NOT meet ambulance medical necessity</u>, please sign below to authorize billing to the requesting party.

Name: Signature: Date:

If patient <u>does meet NEMT medical necessity</u>, select all that apply below:

<u>Monitoring Requirements</u>

- ☐ Airway monitoring
- ☐ Abnormal vital signs monitoring
- ☐ Cardiac monitoring
- ☐ Mental status monitoring due to abnormal behavior, altered mental status, CVA, medication or syncope
- ☐ Orthopedic/medical device monitoring
- ☐ Palliative support related to hospice care
- ☐ Passive/manual restraint to prevent patient injury or medical device movement/tampering
- ☐ Flight risk due to dementia or altered mental status and unable to follow commands
- ☐ Flight risk due to 5150 hold (must include a copy of the 5150 form)
- ☐ Isolation/infection precautions due to: _____

<u>Treatment Requirements</u>

- ☐ Oxygen administration (medical attendant required to regulate
- ☐ Suctioning as needed
- ☐ Restraints needed during transport
- ☐ IV meds or fluid Describe:_____
- ☐ Other treatment/device not listed Describe:_____

<u>Describe in detail the mode of NEMT.</u>

☐ Ambulance/Gurney Van ☐ Wheelchair Van ☐ Litter Van ☐ Air Transport

<u>Describe why the patient can only be transported by NEMT and why patient cannot reasonably ambulate with assistance</u> <u>or be transported by NMT (e.g. Uber, Lyft or Taxi)</u>.

Is the patient bed-confined? If so, describe why: Check one: ☐ **YES or NO** ☐
"Bed-confined" means unable to stand, ambulate <u>and</u> sit in a chair.

<u>Diagnosis</u> (Please include diagnosis explaining why patient requires NEMT (e.g. paraplegic):

Section 4 – Signature of Healthcare Professional (MD/DO/NP/PA/DDS/DPM/Mental Health Prof or SUD provider)

I certify that the above information is accurate and complete based on my evaluation of this patient and demonstrates that the patient requires NEMT because other forms of transport would endanger the patient's health. I understand that this information will be used by CCHP to support the determination of medical necessity for NEMT services. I represent that I have personal knowledge of the patient's condition at the time of transport. **(This form must be signed by an MD, DO, NP, PA, DDS, DPM, Mental Health Prof, or SUD provider)**

_____ Signature of Healthcare Professional (MD/DO/NP/PA/DDS/DPM/MH/SUD)

_____ Date

Print Name _____

_____ NPI/License Number

☐ Physician ☐ Dentist	☐ Nurse Practitioner ☐ Podiatrist ☐ Mental Health Provider	☐ Physician's Assistant ☐ SUD Provider

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Revised 08/2022