HFS 2270

Physician Certification Statement

for

Non-Emergency Transportation

Public Act 100-0646

Amended the Illinois Public Aid Code, Nursing Home Care Act and Hospital Licensing Act for development and implementation of the Physician Certification Statement (PCS).

The PCS is a single form that will be utilized by all **Hospitals and Long Term Care (LTC) facilities** when arranging non-emergency transportation.

Hospitals and LTC facilities must complete this form regardless of whether the patient is in feefor-service or enrolled in a managed care health plan.

If a Hospital or LTC facility arranges a Ground Ambulance, Medicar or Service Car transport, the facility must:

- 1) Complete a PCS
- 2) Provide a copy to the transportation provider
- 3) Maintain a copy of the form in its records for a minimum of 6 years

HFS 2270 – Physician Certification Statement (PCS)

MPORTANT: A patient is only eligible for an imbulance transport requests that are for the performance transport requests that are for the provider with the appropria	Certification Statement COMPLETE THIS FORM AND PROVIDE mbulance transportation if, at the time of tran latient's preference, or because assistance is no te type of service is not immediately available g. Y., All fields on this form are mandatory and	EIT TO THE APPROPRIATE asport, he or she is unable to trave needed at the origin or destination does not meet criteria and will n	ulance Transpo AMBULANCE SERVICE R el safely in a personal vehicle, i (to navigate stairs and/or to as	EPRESENTATIVE axi, or wheelchair van. sist or lift the patient), and.
PATIENT INFORMATION: Name:			Date of Birth	ni i
Medicare Beneficiary Identification (MBI) Num	nber:	Medicaid Recipient Identific	ation Number (RIN):	
Commercial Carrier:	Policy Number:	modela recipioni lacitatio	Insured ID:	
Patient's medical reasoning for A				
RANSPORT INFORMATION: Type	e: Discharge to Home or Nursing Facilit	ty Direct Admit to Hospita	I Appointment	
s this destination the closest appropriate provi		, and a second second	- pponting	
If no, why is transport beyond the close				
If no, the closest appropriate provider/f				
		UNKNOWN		
this patient's stay covered under Medicare P				
this a transport to another facility for services				
RIGINATING FACILITY (Spell out - no abb Name:	reviations):	DESTINATION (Spell out - Name:	no abbreviations):	
City: Sta	te: Zip:			_
		City: at the originating hospital? Servi	State:	Zip:
No Bed Available Other (specif Services are available at the originating he MEDIC 1. Is the patient "bed confined"? To be wheelchair. 2. Isolation Precautions. The patient has condition and must be protected from p 3. Oxygen. The patient requires the admi prior to and during transport, and is exp	ospital, but inter-hospital transport was request AL NECESSITY FOR AMBULANCE - 0 "bed confined", the patient must be unable to g a diagnosed or suspected communicable dise.	ted due to: Patient Reques COMPLETE ALL THAT APP yet up from bed without assistance	it Insurance Requirement LY TO PATIENT: b, unable to ambulate and unab	e to sit in a chair or ne public, or has a medic
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For Non-Emergency Transports Only Physician Certification Statement (PCS) for Medicar/Service Car Transport FACILITY REPRESENTATIVE - COMPLETE THIS FORM AND PROVIDE IT TO THE APPROPRIATE MEDICAR/SERVICE CAR REPRESENTATIVE IMPORTANT: A patient is only eligible for Medicar/Service Car transportation if, at the time of transport, he or she is unable to travel safely in a personal vehicle, taxi, or by public transportation. All fields on this form are mandatory and must be legible. PATIENT INFORMATION: Name: Medicaid Recipient Identification Number (RIN): Commercial Carrier: TRANSPORT INFORMATION: Type: Discharge to Home or Nursing Facility Direct Admit to Hospital Appointment Is this destination the closest appropriate provider? YES NO If no, why is transport beyond the closest appropriate provider? If no, the closest appropriate provider is (name): Is this a transport to another facility for services not available at the originating facility? YES NO ORIGINATING FACILITY (Spell out - no abbreviations): DESTINATION (Spell out - no abbreviations): If an inter-hospital transfer, is it for: Higher level of care? Services not available at the originating hospital? Services needed but not available are: Cardiac Trauma Surgical Hyperbaric Burn Unit Inpatient Dialysis Inpatient Psychiatric Stroke Center Neurology Pediatrics No Bed Available Other (specify): Services are available at the originating hospital, but inter-hospital transport was requested due to: Patient Request Insurance Requirement MEDICAL NECESSITY/CATEGORY OF SERVICE OPTIONS: CATEGORY OF SERVICE OPTIONS: Please select the most economical category of service that will meet patient's needs: MEDICAR/WHEELCHAIR: Public transportation that has an advertised route and Transportation of a patient whose medical Fixed Route Transportation schedule. Some examples of Fixed Route transportation condition requires the use of a hydraulic or include: non-commercial buses, commuter trains, subway trains, electric lift or ramp, wheelchair lockdowns, when the patient's condition does not require medical and elevated trains supervision, medical equipment, the administration of drugs or the administration of ADA Paratransit Curb to curb, shared ride transportation for Americans with Disabilities. Paratransit vehicles include hydraulic or electric lift or ramp and wheelchair lockdowns for patients that can transport independently Transportation by passenger vehicle of a patient Private Auto, Service Car, whose medical condition does not require a Please check all the medical conditions that apply to the patient: Ambulatory - can travel safely using fixed route transportation Wheelchair Bound Ambulatory - does not use a walking device like a walker, cane, etc. Unable to step into regular car Ambulatory - uses walking device like a walker, cane, crutches, etc. Attendant Needed Ambulatory - unable to travel by fixed route transportation Uses transfer wheelchair - able to step into a regular car Medicar Stretcher Needed Attendant Needed CERTIFICATION. I certify that the above information is true and correct based on my evaluation of this patient at or just prior to the time of transport, and represent that the patient requires transport by a Medicar/Service Car and that other forms of transport are contraindicated. I understand that this information will be used by the Illinois Department of Healthcare and Family Services and other payers to support the determination of medical necessity for Medicar/Service Car services. I also certify that I am a representative of the facility initiating this order and that our institution has furnished care or other services to the above named patient in the past. In the event you are unable to obtain the signature of the patient or another Round trip transport (pick up and drop off), date: Repetitive transport, expiration date*: Signature of Licensed Medical Professional Printed Name of Attending Physician (if not signed by the physician) Date Signed Phone Number Printed Name of Licensed Medical Professional "Must be signed only by patient's attending physician for scheduled, repetitive transports, and in such cases is only valid for 180 days. For non-repetitive, unscheduled transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below, Physician -MD/DO Physician Assistant Clinical Nurse Specialist Registered Nurse Nurse Practitioner Discharge Planner LTC Medical Director

PCS Form

PCS is required for Non-Emergency Transports ONLY

 Needed any time a non-emergency transport originates from Hospitals or LTC Facilities

• 2 Sided Form – Only complete <u>one side</u> (not both)

Front – Ground Ambulance

Back – Service Car / Medicar

PCS Form

There are 4 sections of the PCS Form:

- 1) Patient Information
- 2) Transportation Information
- 3) Medical Necessity
- 4) Certification and Signature

PCS - Patient Information

PATIENT INFORMATION: Name:	Date of Birth:	
Medicare Beneficiary Identification (MBI) Number :		Medicaid Recipient Identification Number (RIN):
Commercial Carrier:	Policy Number:	Insured ID:
Patient's medical reasoning for Ambulance	Transport:	

Enter All Available Information

Name and RIN are <u>required</u> for Medicaid patient

Date of Birth is also helpful especially if there are 2 participants with the same name

Policy Number and ID required for all other insurance and Medicare

Patient's medical condition <u>MUST</u> be completed when transport is via Ambulance giving reason that Ambulance transport is needed.

Not required for Medicar/Service Car

PCS - Transport Information

TRANSPORT INFORMATION: Type: Discharge to Home or Nursing Facility	Direct Admit to Hospital	Appointment
Is this destination the closest appropriate provider/facility? YES NO		
If no, why is transport beyond the closest appropriate provider/facility?		
If no, the closest appropriate provider/facility is (name):		

SINGLE OR ROUND TRIP TRANSPORTS

Type of Transport – Must check 1 box of 3.

Closest Appropriate Facility

- Must check "yes or no".
- If no, must give reasoning.

"Appropriate" includes patient's condition, availability of service to meet patient's needs

PCS - Transport Information (cont'd)

Is this patient's stay covered under Medicare Part A (PPS/DRG)? YES NO UNKNOWN						
Is this a transport to another facility for se	Is this a transport to another facility for services not available at the originating facility? YES NO					
ORIGINATING FACILITY (Spell out - no	o abbreviations):		DES	TINATION (Spell out - n	o abbreviations):	
Name:			Nam	e:		
City:	State:	Zip:	City:		State:	Zip:
875 NO 51 DE NO 75 DE 1990 NE 1				/075 EX	75 25050 N500 USE	73

SINGLE TRANSPORT

Medicare Part A (PPS/DRG) – <u>Must</u> check yes, no or unknown

Service Availability at Originating Facility – <u>Must</u> check yes or no if <u>not</u> a hospital discharge

Originating Facility and Destination – <u>Must</u> include all available information. No abbreviations!

AMBULANCE – Valid for up to 60 days

MEDICAR/SERVICE CAR – Valid for up to 180 days

PCS - Transport Information (cont'd)

If an inter-hospital transfer, is it for: Higher level of care? Services not available at the originating hospital? Services needed but not available are:				
Cardiac Trauma Surgical Hyperbaric Burn Unit Inpatient Dialysis Inpatient Psychiatric Stroke Center Neurology Pediatrics				
No Bed Available Other (specify):				
Services are available at the originating hospital, but inter-hospital transport was requested due to: Patient Request Insurance Requirement				

IF INTER-HOSPITAL TRANSFER

Must check if "Higher Level of Care" or "Services Not Available at Originating Hospital"

- If services not available, must identify which services were not available

If Services are available, must check the box and check reasoning

- "Patient Request" applies when services are available and patient still wants to leave
- "Insurance Requirement"

PCS - Medical Necessity (Ambulance)

	MEDICAL NECESSITY FOR AMBULANCE - COMPLETE ALL THAT APPLY TO PATIENT:
	s the patient "bed confined"? To be "bed confined", the patient must be unable to get up from bed without assistance, unable to ambulate and unable to sit in a chair or wheelchair.
	solation 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. 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.
-	Ventilation/Advanced Airway Management. The patient requires advanced continuous airway management by means of an artificial airway through tracheal intubation (nasotracheal tube, or otracheal tube, or tracheostomy tube) prior to and during transport, and is expected to require the treatment after transport.
	Suctioning. The patient requires suctioning to maintain their airway, or the patient requires assisted ventilation and/or apnea monitoring, prior to and during transport, and is expected to require the treatment after transport.
6. l	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.
7. 0	Chemical Restraints or Physical Restraints.
	Chemical Restraints - The patient requires the administration of a chemical restraint during transport, or is under the influence of a previously-administered chemical restraint prior to transport, and the chemical restraint is for the explicit purpose of reducing a patient's functional capacity.
	Physical Restraint - The patient requires physical restraints that are required prior to transport and which are maintained for the duration of transport.
8. 0	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 for the duration of the transport. Elopement Risk Danger to Self or Others a. Dementia/Alzheimers with altered mental states
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 due to: Decubitus Ulcers on the (location): Buttocks Coccyx Hip with (stage): Stage 3 Stage 4 and/or b.contractures, specify:
11.	Clinical Observation. The patient requires clinical observation due to:
12.	Unable to maintain a safe sitting position for the length of the time of transport due to:
13.	Other (specify):

Check **ALL** boxes that apply

PCS - Medical Necessity (Medicar/Service Car)

MEDICAL NECESSITY/CATEGORY OF SERVICE OPTIONS: CATEGORY OF SERVICE OPTIONS: Please select the most economical category of service that will meet patient's needs:				
	SERVICE CAR:		MEDICAR/WHEELCHAIR:	
Fixed Route Transportation	Public transportation that has an advertised route and schedule. Some examples of Fixed Route transportation include: non-commercial buses, commuter trains, subway trains, and elevated trains.	Medicar	Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, when the patient's condition does not require medical supervision, medical equipment, the	
ADA Paratransit	Curb to curb, shared ride transportation for Americans with Disabilities. Paratransit vehicles include hydraulic or electric lift or ramp and wheelchair lockdowns for patients that can transport independently.		administration of drugs or the administration of oxygen, etc.	
Private Auto, Service Car, Taxi	Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.			

Category of Service Options

Must Check which Category of Service (not both)

Left side for Service Car and Fixed Route transports (no assistance needed)

Right side for Medicar (requires lift or ramp but no medical supervision)

PCS - Medical Necessity (Medicar/Service Car (cont'd)

Please check all the medical conditions that apply to the patient:	
Ambulatory - can travel safely using fixed route transportation	Wheelchair Bound
Ambulatory - does not use a walking device like a walker, cane, etc.	Unable to step into regular car
Ambulatory - uses walking device like a walker, cane, crutches, etc.	Orlable to step into regular car
Ambulatory - unable to travel by fixed route transportation	Attendant Needed
Uses transfer wheelchair - able to step into a regular car	Medicar Stretcher Needed
Attendant Needed	

Left side for Service Car and Fixed Route transports

Right side for Medicar

Only complete one side of form

Must check ALL medical conditions that apply (at least 1 condition) under specific Category of Service

PCS - Signature and Certification

and that other forms of transport are contraindicate Services and other pavers to support the determina	d. I understand that this information will be used by the Centers for Medicare a tion of medical necessity for ambulance services. I also certify that I am a rep	he time of transport, and represent that the patient requires transport by ambulance and Medicaid Services (CMS), the Illinois Department of Healthcare and Family resentative of the facility initiating this order and that our institution has furnished care ther authorized representative, my signature below is made on behalf of the patient
Single trip, date:	Round trip transport (pick up and drop off), date:	Repetitive transport, expiration date*:

Check the appropriate box for Single Trip, Round Trip or Repetitive Trip

- Must include date of transport for Single or Round Trip Transport
- Must include expiration date for Repetitive Transport

For Repetitive Transports:

AMBULANCE – Valid for up to 60 days

Medicar/Service Car – Valid for up to 180 days

PCS - Certification and Signature (cont'd)

MANAGEMENT		MANAGEMENT
Signature of Licensed Medical Professional	Date Signed	Printed Name of Attending Physician (if not signed by the physician)
	Phone Number	
Printed Name of Licensed Medical Professional		
*Must be signed only by patient's attending physician for scheduled, repetitive transports, and in such cases a attending physician, any of the following may sign (please check appropriate box below):	s only valid for 60 days	s. For non-repetitive, unscheduled transports, if unable to obtain the signature of the
Physician - MD/DO Physician Assistant Clinical Nurse Specialist Regis	tered Nurse N	lurse Practitioner Discharge Planner LTC Medical Director
HFS 2270 (N-8-18)	119-0132 (1917)	

Licensed Medical Professionals / Attending Physician must:

- Sign Form
- Must include date signed
- Check appropriate box of title/credentials (No LCSW unless Discharge Planner)
- LEGIBLY print full name of both signer and physician
- Include telephone number to be contacted with questions

PCS - Items to Remember

- PCS forms are for Non-Emergency Transports only!
- Hospitals and LTC facilities must complete this form regardless of whether the patient is in fee-for-service or enrolled in a managed care health plan.
- Use the most current form currently HFS 2270 (R-7-19)
- Only complete the page applicable to the transport. Ambulance side for Ambulance trips or Medicar/Service Car side for Medicar/Service Car trips.
- Form must be kept in medical record for a minimum of 6 years
- Electronic signatures are permitted
- Make sure all pertinent information is included on form.
- Double check to make sure member is eligible for transport
- PCS forms are only sent to First Transit when the transport is for Fee for Service eligible patients
- Providers must work with the other insurances (Medicare, HealthChoice Illinois, private, commercial, etc) for instructions on where to send PCS.
- The PCS is not required prior to transport if it would cause a delay that would negatively affect the patient outcome. The hospital/LTC is required to provide the PCS form to the provider within 10 days.
- Print legibly or type into form!