

Physician Certification Statement (PCS) for NEMT

Submit referral in ccLink, on the CCHP Provider Portal or Fax to (925)313-6458 and include a face sheet and 5150 form if on a hold. Contact CCHP at 1(877)800-7423 (Press 3) for questions

Section 1 – Patient Information

Last Name:	First Name:	Date of Birth:
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Section 2 – Transport Information

Dates Requested: _____ to _____	From: _____	To: _____
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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 **does NOT meet ambulance medical necessity**, please sign below to authorize billing to the requesting party.

Name: _____	Signature: _____	Date: _____
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If patient **does meet NEMT medical necessity**, select all that apply below:

Monitoring Requirements

- 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: _____

Treatment Requirements

- 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: _____

Describe in detail the mode of NEMT requested and why the patient can only be transported by NEMT. Specifically, why member cannot reasonably ambulate with assistance or be transported by NMT.

Is the patient bed-confined? If so, describe why: Check one: YES or NO

"Bed-confined" means unable to stand, ambulate and sit in a chair.

Section 4 – Signature of Physician (for Medi-Cal) or other Healthcare Professional

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. **(For all Medi-Cal patients, this form must be signed by a physician)**



Signature of Physician (for Medi-Cal) or other Healthcare Professional

Date

Print Name

NPI/License Number

- | | | |
|--|---|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Physician's Assistant | <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Discharge Planner |

Important Notice: Incomplete forms will be sent back for completion. Unauthorized, non-emergent, or non-urgent services rendered without prior authorization and/or after valid authorized dates are subject to payment denial. Please allow CCHP the following turnaround time to make a decision **after receipt of reasonably necessary information: Standard: up to 5 business days • Urgent: up to 72 hours**

AUTHORIZATION IS CONTINGENT UPON VERIFICATION OF ELIGIBILITY AT THE TIME OF ADMISSION OR AT THE TIME SERVICES ARE RENDERED.

PLEASE DO NOT WRITE IN THE SECTION BELOW • FOR CCHP/PCN USE ONLY

- Approved: Authorization Number: _____ Effective Date: _____
- Modified: Approved per criteria#: _____ Effective Date: _____
- Denied: Reason for Denial _____
- Pt. not eligible HPAR/RN/MD Signature: _____

MEDI-CAL MEMBERS may self-refer to Dental care by calling: (800) 322-6384 and self-refer for Mental Health services by calling (888) 678-7277 PA001 (02/2019)