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: _____ Date of Birth: _____

Medicaid Recipient Identification Number (RIN): _____

Commercial Carrier: _____ Policy Number: _____ Insured ID: _____

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): _____ City: _____ State: _____

Is this a transport to another facility for services not available at the originating facility? ☐ YES ☐ NO

ORIGINATING FACILITY (Spell out - no abbreviations):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DESTINATION (Spell out - no abbreviations):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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:

CHOOSE ONLY ONE SIDE

CATEGORY OF SERVICE OPTIONS: Please select the most economical category of service that will meet patient's needs:

SERVICE CAR:

☐ 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.
☐ 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.
☐ Private Auto, Service Car, Taxi	Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.

MEDICAR/WHEELCHAIR:

☐ 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 administration of drugs or the administration of oxygen, etc.

Please check all the medical conditions that apply to the patient:

- ☐ Ambulatory - can travel safely using fixed route transportation
- ☐ Ambulatory - does not use a walking device like a walker, cane, etc.
- ☐ Ambulatory - uses walking device like a walker, cane, crutches, etc.
- ☐ Ambulatory - unable to travel by fixed route transportation
- ☐ Uses transfer wheelchair - able to step into a regular car
- ☐ Attendant Needed
- ☐ Wheelchair Bound
- ☐ Unable to step into regular car
- ☐ Attendant Needed
- ☐ Medicar Stretcher 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 authorized representative, my signature below is made on behalf of the patient.

☐ Single trip/Round trip, date: _____ ☐ Ongoing transport, start date: _____ and expiration date: _____

_____ _____

Signature of Licensed Medical Professional 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**

☐ **Licensed Practical Nurse (LPN)** ☐ **Licensed Vocational Nurse (LVN)** ☐ **Social Worker** ☐ **Caseworker**