Driscoll Health Plan

Non-Emergency Ambulance Prior Authorization Request

1.) Is an ambulance the only appropriate means of transport? Yes ☐ No ☐
2.) If no, this client does not qualify for non-emergency ambulance transport.
3.) If yes, please complete the remainder of the form.

In order for this service to be covered, the service must be medically necessary and reasonable. Medical necessity is established when the client's medical condition is such that the use of an ambulance is the only appropriate means of transport, and other alternate means of transport are medically contraindicated. Alternate means of transport include services provided through Medicaid's Medical Transportation Program.

This form is to be completed by the provider requesting non-emergency ambulance transportation.

Date Request Submitted: _____

Submitted by Fax: (866) 741-5650

Requesting Provider Name: _____
Provider TPI: _____ NPI: _____ Taxonomy: _____
Contact Name: _____
Phone: _____ Fax: _____

Ambulance Provider Name: _____
Ambulance Provider TPI: _____ NPI:_____ Taxonomy:_____

Client Information
Last Name: _____ First Name: _____ MI:_____
DOB:__/__/__ __ Client Medicaid Number: _____

Client's Current Condition Affecting Transport
Diagnosis Affecting Transport: _____
_____

(Check each applicable condition)
- ☐ Client required monitoring by trained staff because
  - ☐ Oxygen ☐ Airway ☐ Suction
  - ☐ Cardiac ☐ Comatose ☐ Life Support
- ☐ Ventilator dependent
- ☐ Poses immediate danger to self and others
- ☐ Continuous IV therapy or parental feedings*
- ☐ Physical restraint or chemical sedation
- ☐ Decreased level of consciousness*
- ☐ Isolation precautions (VRE, MRSA, etc.) *
- ☐ Wound precautions*
- ☐ Advanced decubitus ulcers
- ☐ Contractures limiting mobility
- ☐ Must remain immobile (i.e., fracture, etc.) *
- ☐ Decreased sitting tolerance time or balance*
- ☐ Active seizures*

*****Provide additional detail. (i.e. type of seizure or IV therapy, body part affected, supports needed, or time period for the condition), or provide detail of the clients other conditions requiring transport by ambulance.

_____
_____
_____

☐ Extra attendant Reason:_____

Reason for Transport Hospital discharge? ☐ Yes ☐ No If yes, expected transport time: _____
Other purpose: _____
Origin: _____ Destination: _____

Method of Transport: ☐ Ground ☐ Fixed Wing ☐ Helicopter ☐ Specialized Vehicle

Request Type:
- ☐ One Time
- ☐ Short Term (more than one transport) Begin Date: __/__/__ __
- ☐ Long Term (many transports) End Date: __/__/__ __

*Physician signature required for Short Term and Long Term

Certification: I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

Name: _____ Title: _____ Provider Identifier: _____
Physician Signature: _____ Date Signed: __/__/__ __