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| **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 NPI: \_\_\_\_\_\_\_\_\_\_\_ Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_  Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ambulance Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ambulance Provider 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 client's 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: \_\_/\_\_/\_\_ \_\_ | | | |