

REQUEST FOR TRANSPORTATION
must be completed to Schedule the transport

Person Requesting: _____ Preferred Phone# _____ Today's Date ____/____/____

Patient Name: _____ D.O.B. ____/____/____ Sex: ___ M ___ F SSN # _____

Pickup Date: ____/____/____ Requested Pickup Time _____ Promised Time _____ Appt. Time _____

Pickup Location _____ P/U Rm# _____

Destination: _____ phone # _____ Rm # _____

Roundtrip required? _____ If yes, who is responsible for the payment? (Name/Address) _____

Special Equipment/Needs? IV Monitor O2 Vent/Trach Weight 250+ Other _____

- **Is this patient coming from or going to a Skilled Nursing Facility?** Yes No
 - If Yes, is it in the Part A period (1st 100 days of stay)? Yes No
 - If Yes, what service is the patient being transported to receive? _____
- **Is the patient an in-patient at the hospital?** Yes No
 - If Yes, are they being discharged from this hospital? Yes No
 - If No, what service is the patient being transported to receive? _____

Private / Self Pay Insurance Information: (Please print or type) Medicaid/Medicare # _____

Insurance Company/Responsible Party: _____

Mailing Address: _____

Policy / P.O. Number: _____ **Insurance Pre-authorization #** _____

Who from your facility will be financially responsible for authorizing this transport if coverage is denied?

Name: _____

A Physician Certification Statement (PCS) is required for all Medicare patients. Please complete the PCS section below. If the patient is going to or from a dialysis center, chemotherapy, radiation therapy or wound care, the **PCS must be signed by the patient's physician.**

Physician Certification Statement		
<p>In order to meet medical necessity as defined by Medicare the patient must meet one of the following four criteria. Transportation by ambulance is needed for this patient for the following reason:</p>		
<p>1. Bed confined at the time of transport: (All must apply if checked)</p> <p><input type="checkbox"/> Unable to ambulate, unable to get up without assistance and unable to sit in a chair or wheelchair</p>	<p>2. ALS monitoring required – (check applicable condition)</p> <p><input type="checkbox"/> Cardiac/hemodynamic <input type="checkbox"/> Advanced Airway Management <input type="checkbox"/> IV meds required <input type="checkbox"/> Chemical Restraint</p>	<p>3. Monitoring required –</p> <p><input type="checkbox"/> Suction <input type="checkbox"/> Airway control/positioning <input type="checkbox"/> Third Party Assistance</p>
<p>4. Medical Conditions that contraindicate transport by other means: (check applicable condition)</p> <p><input type="checkbox"/> Patient Safety-danger to self or others <input type="checkbox"/> Needs Medical Observation <input type="checkbox"/> Communicable disease <input type="checkbox"/> Contractures <input type="checkbox"/> Hazardous material exposure <input type="checkbox"/> Morbid obesity <input type="checkbox"/> Special handling to avoid further injury <input type="checkbox"/> unable to be transported in seated position due to decubitus ulcers of buttocks, coccyx, hip, sacrum and stage _____. <input type="checkbox"/> Positioning in wheelchair or standard car seat inappropriate due to contractures or recent extremity fractures <input type="checkbox"/> Paralysis ____hemi____para____quad <input type="checkbox"/> Fracture of the _____ <input type="checkbox"/> Unsafe to be transported in seated position due to _____.</p>		
<p>Only a Physician can sign for Repetitive Patients (defined as transported for same condition once a week for 3 consecutive weeks or 3 times in a 10 day period)</p> <p>I certify that our institution has furnished care or other services to the above named patient. In the event that you are unable to obtain the signature of the patient or another authorized representative, I hereby sign on the patient's behalf. This signature is not an acceptance of financial responsibility for the patient.</p>		
<p>Physician's Signature: _____ Physician's Name: _____ (Please print or type)</p>		
<p>*Signature: _____</p>		<p>Date: ____/____/____</p>
<p>*Non-Repetitive Patients - Circle One: MD RN Discharge Planner Nurse Practitioner Clinical Nurse Specialist</p>		