

# Non-Emergent Transportation Request

Phone: (716) 631-3282 Fax: (716) 635-3910

**NOTE: all fields on this form must be completed. If not, delay of determination may result. Please be advised that Independent Health must have the necessary information to process the request timely.**

## REQUESTING PROVIDER/FACILITY INFORMATION:

**NAME:** \_\_\_\_\_ **NPI:** □□□□□□□□□□  
**Contact Name:** \_\_\_\_\_ **TAX ID:** □□-□□□□□□□□  
**Phone Number:** (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ **Ext:** \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

## REQUESTED SERVICE(S):

Ambulance  Air Ambulance  Stretcher Van  Wheelchair Van  Taxi Cab

**Transportation Date:** \_\_\_\_\_ **Number of One Way Trips:** \_\_\_\_\_  
**From:** \_\_\_\_\_ **To:** \_\_\_\_\_  
**Transportation Provider:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Contact Person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

## MEMBER INFORMATION:

**MEMBER ID:** □□□□□□□□□□ **SUFFIX:** □□  
**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Home/Cell Phone:** (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ **Address:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip code:** \_\_\_\_\_  
**DIAGNOSIS CODES (ICD-10):** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

## PHYSICIAN'S MEDICAL NECESSITY CERTIFICATION:

Non-emergent ambulance transportation requires a physician attestation of medical necessity for prior consideration. This tool has been designed to assist in determining if Medical Necessity criteria have been met.

### Rationale:

**Require documentation that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.**  
**Include all supporting clinical documentation with request.**

I certify that the above information represents an accurate assessment of the patient's medical condition(s) and that in my professional medical opinion, this patient's transportation needs can only be met by ambulance and the member cannot be transported by any other means.

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Would processing of this request after seventy-two (72) hours, place the member's life, health or ability to regain maximum function in serious jeopardy?**  NO  YES