AMBULANCE TRANSFER REQUEST FORM

Please call your EMS Provider for Stat or Emergent Requests.

Instructions for Ambulance Request:

1. Please verify the patient meets medical necessity criteria per CMS Guidelines. Additional riders are approved at the discretion of the EMS Provider.
2. Obtain insurance authorization, if required by patients insurance.
3. Facility must complete the Medical Necessity Form and the Transfer Request Form.
4. Prior to transport, the facility will send the following documents to the EMS Provider via email or fax: Medical Necessity Form, Transfer Request Form, History & Physical Notes and Patient Face Sheet. Failure to send all documents at initial request may delay ambulance response.
5. Once form is received, EMS Provider will contact the Requester to confirm/decline transport or negotiate pick up time.
6. If the patient does not meet Medical Necessity to ride by ambulance, the Facility may be asked to sign a payment authorization.
7. Conditions when a patient may be asked to pay before the trip: if they have not met their insurance deductible, if they are not going to the residence on file with Medicare/Medicaid, if they do not meet medical necessity and facility will not accept financial responsibility.
8. If patient is going to a residence, they cannot be left unattended. Facility must provide contact information for person at the residence and amount of stairs at residence if applicable. For patient safety, stairs may require extra personnel or equipment.
9. Repetitive requests will require an on site visit by EMS personnel. If approved, Medical Necessity and Site Survey must be resubmitted every 60 days.

Prepared By: ______________________________ **Contact #:** ____________________

Patient Name: ______________________________ MRN: ____________________

Is patient on a vent? YES NO If yes, does EMS need to bring a vent? YES NO

Vent Settings: ____________________ ISO Precautions: ____________________

Please Select: [ ] One-way Transfer [ ] Transfer with Return Trip [ ] Repetitive Trip Request

Transport Date: ____________ Pick-up time: ______________ Appt time: ____________

Facility Name: ______________________________ Ste/Rm#: ____________

Facility Address: ______________________________

Nurse Name: ______________________________ Nurse Phone: ____________________

Who is financially responsible? Facility Insurance Worker's Comp Self Pay/Uninsured

Destination: ______________________________ Ste/Rm #: ____________

Destination Facility: Is this the closest accepting facility? YES NO Is patient going for inpatient rehab? YES NO

If destination is not closest accepting, select why: Diversion Closer Facility denied patient Closer to home/family

List diversion/non-accepting facilities: ______________________________

Residential Destination: Will EMS Crew take patient up/down stairs? YES NO If yes, how many? ____________

Residence Contact Name: ____________________ Relation: ____________ Number: ____________________

Is residence destination the patients address on file with Medicare? YES NO

Rider: Is someone asking to ride with the patient? YES NO If yes, what is the relation to patient?: ____________

Please have the following **information** ready for your EMS Transfer Crew:

___ Facesheet (demographics/insurance)
___ Receiving facility paperwork
___ Transfer Form copy
___ H&P or PT notes (if available)
___ CMN/PCS Form (medical necessity)
___ DNR
___ Recent Vitals (for comparison)
___ Insurance Auth #: ______________

Questions? Please call ____________________ **at** ________________**.**

(EMS Provider) (phone number)