Non-Emergency
AMBULANCE TRANSFER REQUEST FORM

Please call your EMS Provider for Stat or Emergent Requests.

Instructions for Non-Emergency Ambulance Request:

1. Please verify the patient meets medical necessity criteria per CMS Guidelines.
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: ______________

Vent Settings (if applicable): ______________________

Contact/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 no, please list facilities on diversion, or other reason for destination choice: ______________________

Residential Destination: Will EMS Crew need to 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

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 (if applicable–on yellow paper)
___ Recent Vitals (for comparison)
___ Insurance Auth #: ______________

Questions? Please call ______________ at ______________.
(EMS Provider) (phone number)