



NON-EMERGENT TRANSPORTATION REQUEST

DATE:		Please fax request to 267-515-6627.	
PROVIDER NAME:		PHONE:	
Provider ID #:		FAX:	
NPI #:			
Member Name:		Member ID #:	
Member's Height/Weight:		Is this a reauthorization? <input type="checkbox"/> Y <input type="checkbox"/> N	
		If Yes, provide Auth Number: _____	
Dates of Service Requested:		Transport From:	
Transport To:			
Is this for ongoing treatment (ex. Dialysis; Chemo)? <input type="checkbox"/>			
Diagnosis ICD-9 Code:		ICD-9 Code Description:	
Ordering Physician Name:		Phone:	
ATTACHMENTS		Physician Certification Statement (PCS)	
<input type="checkbox"/> <i>PCS (Valid for 60 days from DOS)</i>		previously submitted within 60 days:	
<input type="checkbox"/> <i>LOMN (required when unable to use MATP)</i>		____ Yes No____	
HCPCS Code **	Description	# of Trips (1=1 way)	
A0426	ALS		
A0428	BLS		
A0434	Specialty Care Transport (SCT)		
A0130	Van		
Other Codes			

Additional information:

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.