Wellpoint nonemergency ambulance prior authorization request form

1. Is an ambulance the only appropriate means of transport? ☐ Yes ☐ No
2. If **no**, this member does not qualify for nonemergency ambulance transport.
3. If **yes**, please complete the remainder of the form.

In order for this service to be covered, the service must be medically necessary and reasonable. Medical necessity is established when the member's medical condition is such that the use of an ambulance is the only appropriate means of transport, and other alternate means of transport are medically contraindicated.			
This form is to be completed by the entity requesting nonemergency ambulance transportation. Submit this form by fax at: **866-959-1537** or for behavioral health: **844-430-6804**			
Date request submitted:			
Requesting provider name:			
Provider TPI:		**NPI:**	
Taxonomy:		**Contact name:**	
Phone:		**Fax:**	
Ambulance provider name:		**Ambulance provider identifier:**	
Member Information			
Last name:			
First name:		**MI:**	
DOB:		**Member Medicaid no:**	
Member's current condition affecting transport			
Diagnoses affecting transport:			
(**Check** each applicable condition) Member requires monitoring by trained staff because: ☐ Oxygen ☐ Airway ☐ Suction ☐ Cardiac ☐ Comatose ☐ Life support ☐ Ventilator dependent ☐ Poses immediate danger to self or others ☐ Continuous IV therapy or parenteral feedings*	☐ Physical restraint or chemical sedation* ☐ Decreased level of consciousness* ☐ Isolation precautions (VRE, MRSA, etc.) * ☐ Wound precautions* ☐ Advanced decubitus ulcers* ☐ Contractures limiting mobility* ☐ Must remain immobile (in other words, fracture, etc.)* ☐ Decreased sitting tolerance time or balance* ☐ Active seizures*		

* Provide additional detail (in other words, type of seizure or IV therapy, body part affected, supports needed, or time period for the condition), or provide detail of the member's other conditions requiring transport by ambulance.		
Extra attendant reason:		
Reason for transport		
Hospital discharge? ☐ Yes ☐ No	**If yes,** expected transport time:	
Other purpose:		
Origin:		
Destination:		
Method of transport: ☐ Ground ☐ Fixed wing ☐ Helicopter ☐ Specialized vehicle		
Begin date		End date	
Frequency of transportation needed:		
Certification: I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and / or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.		
Name		
Title		
Signature		**Date signed**	