Geisinger Health Plan

NON-EMERGENT AMBULANCE TRANSPORT REQUEST

FAX TO GHP: (844) 545-0102 or (570) 214-2430
PHONE GHP: (844) 749-5860 or (570) 214-2459

GENERAL INFORMATION (fill all fields and check all boxes that apply)

Authorization #:
(GHP internal use only)

Requestor Name:		Request Date:
Request Time:	Requestor Phone:	Requestor Fax:
Patient Name:		Patient DOB:
Gender: ☐ M ☐ F	Patient Weight:	Patient Insurance ID #:

TRIP INFORMATION (fill all fields and check all boxes that apply)

Pickup Location Name:		Destination Name:	
Street Address (include unit/floor/room/apt #):		Street Address (include unit/floor/room/apt #):	
City:	State:	City:	State:
Zip:	Phone:	Zip:	Phone:
Mode of Transportation Requested: ☐ **WHEELCHAIR** ☐ **AMBULANCE** ☐ **OTHER -** describe:			
Transport Date:	Pickup Time:	Appointment Time:	
☐ Round Trip	Time of Return (Will Call or Pickup Time):	☐ Recurring Transports	☐ Discharge ☐ MD Office Visit
☐ **Patient needs procedures or tests that cannot be performed at point of origin (e.g., hospital, SNF, residence, etc.)**			
☐ Facility to Facility Transfer (e.g, hospital to hospital, hospital to ASC)		☐ Specialized services or care not available at first facility	
List services:			
☐ Destination is the closest appropriate facility; If not, describe:		☐ RT, RN, or MD flight crew required	
Describe why patient needs an ambulance and cannot be transported by other means:			

PATIENT INFORMATION (fill all fields and check all boxes that apply)

Current Diagnosis:		Attending Physician:
Special Circumstances:		
☐ Patient ambulates ☐ Gets up from be w/o assistance ☐ Sits in chair/wheelchair ☐ Immobile/hip precautions ☐ SNF Part A patient ☐ Required services are covered under patient's plan of care ☐ Oxygen; Via: ☐ Administers own oxygen; If so, what is medical reason:	☐ Meds infusing; If so, list meds: ☐ IV running; If so, list type of IV and meds: ☐ Cardiac monitor ☐ Tracheostomy care ☐ Ventilator ☐ Sedated for ventilation ☐ Tracheal suctioning needed ☐ Sedated; If so, how:	☐ Psychological/behavioral transport ☐ Involuntary; If so, committed by: Precipitating behavior: ☐ Restrained; If so, type: ☐ Patient suicidal ☐ Patient homicidal ☐ Additional attendant; who/why: ☐ Lift Assist Needed

*Required Information. Incomplete forms will be returned unprocessed.
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.