transdev
the mobility company

Medical Certification for BLS/ALS Transportation

The member's medical provider must complete this form to verify the medical necessity of Basic Life Support (BLS) or Advanced Life Support (ALS) transportation.
Once complete, please fax, email, or mail

Patient Info	First Name:	Last Name:	DOB	Health First Colorado ID#
Medical Facility Info	Facility Name			
	Facility Address (Street Address, City, State, Zip)			
	Medical Provider's Name & Title			
	Contact Name and Title			
	Contact Phone	Contact Email		
Type of Transport Requested:	☐ ALS	☐ BLS	☐ Stretcher Van	
Reason Patient Requires BLS or ALS Transportation (attach additional documentation if necessary)				
Medical Provider Attestation	I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge			
	Printed Name of Facility Staff	Title		
	Signature of Facility Staff	Date		
Term of Verification	For an Indefinite Term?	(if not) From	To	

Please send completed form to: Fax (720) 302.0106 | Email: us.coclinicalcoordinator@transdev.com

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