

# Non-Emergent Medical Transportation Request Form

Complete this form to request Non-Emergent Medical Transportation (NEMT) for Health First Colorado members who need in-state transportation or out-of-state transportation. Please note, the Department must be pre-approve all out-of-state requests prior to date of service and the Member must be eligible for NEMT services in order for authorization to be granted. Authorizations will be given for medically necessary services only. Forms should be submitted a minimum of seven business days in advance of date of travel.

*By signing below, I certify that the information provided on this form has been completed by a medical professional and all supporting medical documentation has been submitted with this request including medical necessity forms and/or Prior Authorization Form (PAR)*

Medical Professional Signature

Date Signed

Provider NPI

## Medical Professional Information

*List contact information for the referring Colorado provider for any questions or concerns regarding this request:*

Contact Name (Last Name, First Name):	Contact Phone Number:	Contact Email Address
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## Member Information

Health First Colorado ID Number:	Member Name (Last Name, First Name MD):	Date of Birth:
Member Address (for Member pick-up location; no PO Box):		Member Phone Number:

## Provider Information

Provider 1	Referring Provider Name:	Appointment Date:	Type of Appointment: Inpatient      Outpatient	Referring Provider has confirmed appointment date with Accepting Provider Yes      No
	Treating Provider Contact information:	Appointment Address:		<i>Please note, any changes after submitting the request from will cause delays in scheduling of the trip.</i>
Provider 2	Accepting Provider Name:	Appointment Date:	Type of Appointment:	Appointment Time & Duration:
	Accepting Provider Contact information:	Appointment Address (including city, state and zip code)		

Additional Comments:

## Travel Details

Type of Travel: * Air Ambulance * Personal Vehicle * Commercial Air (In-state) * Commercial Air (out of state)	Departure Date:	Return Date:
Meals Reimbursement Required? * Yes * No	Lodging Reimbursement Required? * Yes * No	Departure City/Airport:
Please note if member requires any assistance at airport	Type of Airline Ticket: * One way * Round trip	Height/Weight (only needed for air ambulance transports): Height:      Weight:

## Escort Information

Companion Required? * Yes * No <b>*If yes, will require Medical Necessity Form</b>	
Name & Birth date of Adult Escort (as listed on valid photo ID):	Height/Weight (only needed for air ambulance):
Does the escort need a return airline ticket? (only for EPSDT cases and for air ambulance or commercial airline flights) Yes      No	Additional Comments:

## Ground Transportation (only for air request)

Is transportation needed from member's home to airport * Yes * No	Required from airport to back Home * Yes * No
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## Medical Needs

Wheelchair Required? * Yes * No	Has own wheelchair? * Yes * No If yes, indicate type of wheelchair:
Gurney Required? * Yes * No	Can member transfer? * Yes * No

**A letter of Medical Necessity and Clinical Documents must be uploaded. If they are not uploaded, the request will be denied and must be resubmitted.**

Letter of Medical Necessity: Yes      Clinical Documentation: Yes