



Pre-Authorization for Non-Emergent Ground Ambulance Transport

Please fax this completed form to: 1-888-282-0780

Non-emergent ambulance transport is a covered benefit only when all three medical necessity criteria below are met. If medical necessity cannot be established, Blue Cross Blue Shield of Massachusetts will conduct a clinical review. Please submit request for preauthorization to BCBSMA seven days prior to date of transport.

Ambulance Provider: _____	Member Name: _____
Ambulance Provider NPI: _____	M F
Date of Request: _____	Subscriber #: _____
First Date of Service: _____	Member Date of Birth: _____
Contact Person: _____	Diagnosis: _____
Telephone: () _____	Clinical Update Date: _____
Physician in charge of patient's care: _____	Physician NPI: _____
	Physician Telephone: () _____
Physician/Designee Signature: _____	

Transport Type:	From:	To:	# Runs Requested:	Frequency/Week:

Medical Necessity Criteria for Non-emergent Ambulance Transport
Patient must meet all 3 criteria to be eligible for transport.

- Member is bed-confined:

Yes No

To meet definition of bed-confined, member must meet at least one of these criteria. **Check to indicate which apply:**

Unable to get out of bed without assistance OR

Unable to ambulate AND unable to sit in a chair/wheelchair
 - Transport by other means would endanger the member's health and could precipitate a medical complication.

Yes No

Explain in detail:

 - Diagnosis and present clinical condition supports ambulance transport.

Yes No

Explain in detail. If injury-related, please explain injury:

- Expected length of disability: _____

Outpatient Service Destination

- Scheduled clinic visit Dialysis:
- Radiology (type): _____
- Other: _____

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