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MASSACHUSETTS

PRE-AUTHORIZATION FOR NON-EMERGENT GROUND AMBULANCE TRANSPORT

Please fax this completed form to Clinical Intake at **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 Blue Cross seven days prior to date of transport.

MEMBER INFORMATION

Name:	
Member ID:	
Date of birth:	
Diagnosis:	
Clinical update date:	

PHYSICIAN/PROVIDER IN CHARGE OF THE MEMBER'S CARE

Physician/provider name:	
NPI:	
Phone #:	
Physician/provider or designee signature:	

AMBULANCE PROVIDER & SERVICE INFORMATION

Ambulance provider:			
Ambulance provider NPI:			
Contact person:		Contact phone #:	
Date of request:		First date of service:	

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.

1. 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
2. Transport by other means would endanger the member's health and could precipitate a medical complication. ❑ Yes ❑ No	**Explain in detail:**
3. Diagnosis and present clinical condition supports ambulance transport. ❑ Yes ❑ No Expected length of disability:	**Explain in detail.** If injury-related, please explain injury:

OUTPATIENT SERVICE DESTINATION

❑ Scheduled clinic visit	❑ Dialysis	
	❑ Radiology (type):	
	❑ Other:	