



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: <input type="checkbox"/> Yes <input type="checkbox"/> No	To meet definition of bed-confined, member must meet at least one of these criteria. Check to indicate which apply: <input type="checkbox"/> Unable to get out of bed without assistance OR <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain in detail:
3. Diagnosis and present clinical condition supports ambulance transport. <input type="checkbox"/> Yes <input type="checkbox"/> No Expected length of disability:	Explain in detail. If injury-related, please explain injury:

OUTPATIENT SERVICE DESTINATION		
<input type="checkbox"/> Scheduled clinic visit	<input type="checkbox"/> Dialysis	
	<input type="checkbox"/> Radiology (type):	
	<input type="checkbox"/> Other:	

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