MEDICAID AMBULANCE AUTHORIZATION FORM

A DHEC Run Report must be attached to the DHHS Form 216 when submitting a claim for reimbursement.

Beneficiary's Name: _____ Date of Transport: ____/___/____

Medicaid ID Number: _____

_____Ambulance Service, Basic Life Support, Non-Emergency Transport (BLS) – Procedure Code A0428
(A DHEC licensed Ambulance vehicle with staff and equipment on board that provides **active, ongoing** medical treatment in basic life situations.)

I understand that Medicaid will only cover transport to Medicaid-sponsored services in accordance with the listed limitations. This recipient is being transported from and to the following location:

FROM		TO
	Residence	
	Hospital	
	Nursing Home	
	Physician Office	
	Hospital Based Dialysis	
	Non-Hospital Based Dialysis	
	Adult Residential Facility	
	Emergency Vision Care (to age 21)	
	Preventive/Restorative Dental Care (to age 21)	
	Emergency Dental Care (over age 21)	
	Adult Day Health Care	
	Other: **Please Specify**	

ACTIVE, ONGOING MEDICAL TREATMENT
(*Check all that apply and document the details on the DHEC Run Report*):

	Dressing Applied		Oxygen Administered
	Suction Used		Ventilator
	Other Active Medical Treatment: **Please Specify**		

LEVEL OF CARE
***(Check all that apply)*:**

	Suctioning required en route, need for titrated O_2 therapy or IV fluid management		Special handling en route – isolation
	Airway control/positioning required en route		Danger to self or others – seclusion (flight risk)
	Contractures		Danger to self or others - monitoring
	DVT require elevation		Confused, combative, lethargic, comatose
	Special handling en route to reduce pain – orthopedic device		Morbid obesity requires additional personnel/equipment to handle
	Risk of falling off wheelchair or stretcher while in motion (not related to obesity)		Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
	Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transit		Severe muscular weakness and de-conditioned state precludes any significant physical activity
	Other: **Please Specify**		

I certify that it is medically necessary for the patient to be transported by ambulance. Transportation by another means could be detrimental and medically inadvisable. This certification is provided within my professional scope of practice and applicable state law.

_____(Signature of Requestor, Title) Date: ____/____/____
(Attending physician, physician assistant, nurse practitioner, clinical nurse specialist, or registered nurse)

_____(Print Name of Requestor, Title) County: _____

Vehicle odometer reading (To): _____ Vehicle odometer reading (From): _____