CLEAR FORM EMAIL FORM PRINT

LIVINGSTON COUNTY EMS
NON-EMERGENCY TRANSPORT REQUEST

Patient Name: _____ D.O.B. _____

Mailing address _____ Phone _____

Health Insurance: _____ Policy # _____

Group # _____ Policy Holder: _____

Health Insurance: _____ Policy # _____

Group # _____ Policy Holder: _____

Date of Requested Transport: _____ Requested Pick up Time: _____
☐ One Way transport or ☐ Wait and return Appointment Time: _____
If for a procedure list here: _____

Special needs: ☐ Vent dependent ☐ Oxygen ☐Cardiac Monitor ☐Obesity #_____
☐ Dialysis or other recurring procedure ☐ Other: _____

If Altered mental status or nonverbal do they have a representative accompanying them?
☐ YES ☐ NO Name: _____

Pick Up Location Facility Name: _____ Rm#_____
Pick Up Facility Address: _____
Pick Up Facility Contact: _____Phone: _____

Drop Off Facility Name: _____ Rm#_____
Drop Off Facility Address: _____
Drop Off Facility Contact: _____Phone: _____

Reason for Ambulance transport request: _____
Is this patient Bed Confined by CMS definition? ☐ YES ☐ NO

The HCFA definition of Bed-Confinement is: The inability to get up from bed without assistance; ambulate; and sit in a chair, including a wheelchair. (ALL MUST BE MET)