TMHP

Nonemergency Ambulance Prior Authorization Request
Texas Medicaid Program

1.) **Is an ambulance the only appropriate means of transport?** ☐ Yes ☐ No
2.) **If no**, this client does not qualify for nonemergency ambulance transport.
3.) **If yes**, please complete the remainder of the form.

In order for this service to be covered, the service must be medically necessary and reasonable. Medical necessity is established when the client's medical condition is such that the use of an ambulance is the only appropriate means of transport, and other alternate means of transport are medically contraindicated. Alternate means of transport include services provided through Medicaid's Medical Transportation Program or services included in the rate for Long Term Care - Nursing Facilities.

This form is to be completed by the provider requesting nonemergency ambulance transportation.
[Reference: Chapter 32.024(t) Texas Human Resources Code]

Date Request Submitted: _____

Submit by Fax : 1-512-514-4205

Requesting Provider Name: LIFE AMBULANCE SERVICE INC.
Provider TPI: 088211001 **NPI:** 186147762 **Taxonomy:** 34160000X
Contact Name: _____ **Phone:** 915-877-3155 **Fax:** 915-877-2234
Ambulance Provider Name: LIFE AMBULANCE SERVICE INC.
Ambulance Provider Identifier: 186147762 915-877-2234

Client Information

Last Name: _____ First Name: _____ MI: ____

DOB: __ __/__ __/__ __ __ __ Client Medicaid Number: _____

Client's Current Condition Affecting Transport

Diagnoses affecting transport: _____

(**Check** each applicable condition)

- ☐ Client requires monitoring by trained staff because
  - ☐ Oxygen ☐ Airway ☐ Suction
  - ☐ Cardiac ☐ Comatose ☐ Life support
- ☐ Ventilator dependent
- ☐ Poses immediate danger to self or others
- ☐ Continuous IV therapy or parenteral feedings **
- ☐ Physical restraint or chemical sedation **
- ☐ Decreased level of consciousness **
- ☐ Isolation precautions (VRE, MRSA, etc.) **
- ☐ Wound precautions **
- ☐ Advanced decubitus ulcers **
- ☐ Contractures limiting mobility **
- ☐ Must remain immobile (i.e., fracture, etc.) **
- ☐ Decreased sitting tolerance time or balance **
- ☐ Active Seizures **

** Provide additional detail (i.e. type of seizure or IV therapy, body part affected, supports needed, or time period for the condition), or provide detail of the client's other conditions requiring transport by ambulance.

_____

_____

☐ **Extra Attendant** Reason: _____

Reason for Transport Hospital discharge? ☐ Yes ☐ No **If yes,** expected transport time: _____

Other purpose: _____

Origin: _____ Destination: _____

Method of Transport: ☐ Ground ☐ Fixed Wing ☐ Helicopter ☐ Specialized Vehicle

Request Type:

- ☐ One Time, Non-repeating Medicaid or Medicare
- ☐ Short Term (2 - 60 days) Medicaid or Medicare *
- ☐ Long Term (61 - 180 days) Medicaid Only *

* Physician signature required for Short Term and Long Term

Begin Date: __ __/__ __/__ __ __ __
End Date: __ __/__ __/__ __ __ __

Certification: I certify that the information supplied in this document constitutes true, accurate, and complete information and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and / or state law which can result in fines or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

*** Name:** _____ **Title:** _____ **Provider Identifier:** _____

*** Signature:** _____ **Date Signed:** __ __/__ __/__ __ __ __