Neighborhood Health Plan OF RHODE ISLAND™

Non-Emergency Ambulance Transportation
Prior Authorization Form

Please return completed form to the Utilization Management Department at (401)459-6023.
Please refer to Neighborhood's Clinical Medical Policies, which are available on our website, www.nhpri.org, for more detailed information about these benefits, authorization requirements, and coverage criteria.

NOTE: In order for this service to be covered, the service must be medically necessary and reasonable. Medical necessity is established when the member'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.

***Indicates required field(s)**

Member Information* (All fields are required)		
Member's Name:	Member's ID #:	Member's DOB:

Ambulance Supplier Information* (All fields are required)		
Name:	NPI:	Date(s) of Service:
Address:	City, State, Zip Code	
Phone: / Fax:	Contact Name:	

Ordering Provider Information* (All fields are required)			
Name:	NPI:	Phone:	Fax:

Requested Service(s)* (All fields are required)

HCPCS Code	**Origin Modifier**	**Place of Origin** (i.e. name of hospital, group home, etc.)	**Destination Modifier**	**Destination** (i.e. member's home, name of nursing home, etc.)

Clinical Information* (All fields are required)	
*Diagnosis affecting transport:	Diagnosis ICD-10 Code:

Medical Condition(s) that prevent safe transport by any other means - Check each applicable condition:

☐ Member is Bed-Confined – Unable to sit, stand, or walk. (This does not apply to being on bed rest.)

Member requires monitoring by trained staff because:
☐ Airway Monitoring ☐ Cardiac Monitoring
☐ Life Support ☐ Ventilator Dependent ☐ Comatose
☐ Other (please specify): _____

☐ Poses immediate danger to self or others
☐ Active seizures ☐ Medically Unstable
☐ Decreased level of consciousness
☐ Requires isolation due to disease or other exposure
Please specify: _____

Hospital Discharge? ☐ YES ☐ NO	Does the ambulance have the necessary equipment and supplies to address the needs of the member? ☐ YES ☐ NO

ATTENTION: Please complete all fields on the form and submit all clinical documents. Documentation may include MD orders, office notes, and all other evaluations, results of diagnostic testing, and patient's clinical information. Failure to provide sufficient information may delay processing of your request.

Authorization is not a guarantee of payment.

Authorization #:	**Dates of Service:**	**Services Approved:**
UM Initials:	**Notification Date:**	☐ **Not Approved – Letter to Follow**

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