B.3 Ambulance Fax Cover Sheet

Texas Medicaid & Healthcare Partnership
12357-B RIATA TRACE PKWY, STE 150
Austin, TX 78727

DATE: ____________________ TIME: __________(AM) (PM)

FROM: ____________________ TO: AMBULANCE UNIT

PHONE: ____________________ PHONE: 1-800-540-0694

FAX: ____________________ FAX: 1-512-514-4205

*For clients who meet the definition of severely disabled: The client's physical condition limits his/her mobility, which requires the client to be bed-confined at all times or life support systems to be monitored.

If Hospital to Hospital or Hospital Discharge, supply:

ORIGIN: ____________________ DESTINATION: ____________________

All providers supply the following information:

*The requestor's name and title ____________________

*The client's full name ____________________

*The client's Medicaid number ____________________

*The initial transport date ____________________

*Full name of the transporting Ambulance Company ____________________

*Texas Provider Identifier (TPI) of the transporting Ambulance Company ____________________

*National Provider Identifier (NPI) of the transporting Ambulance Company ____________________

*Taxonomy Code of the transporting Ambulance Company ____________________

*The type of Prior Authorization being requested: _____Short Term (1-60 days)

Please supply one or more of the following documentation:

*Admit and discharge records for dates of service

*A history and physical that has been done within 6 months

*The Care Plan with Daily Activity Sheet from the Nursing Home within 6 months

*Home Health Care Plan within 6 months

NUMBER OF PAGES INCLUDING COVER SHEET:____________________

Effective Date_07302007/Revised Date_11142007

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