2019

MEDSTAR MOBILE HEALTHCARE

Facility Reference Document

Hospitals, Clinics, & Skilled Nursing Facilities

Contact Information:

Non-Emergency Transport	(817) 927-9620
Business Office	(817) 923-3700
Business Office Fax	(817) 632-0537
Medical Records	(817) 840-2060
Medical Records Fax	(817) 840-2051

Revised: 08/24/2018

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

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Sending Facility Information Sheet for MedStar Mobile Healthcare Transfers

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
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911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

Medicaid Patients:

Under Texas Law, it is the responsibility of the sending facility to obtain prior authorization for all Non-Emergency transportation for recipients of Medicaid and any Medicaid Managed Care plans as listed on page 3. When calling the MedStar Mobile Healthcare Controllers in the Communication Center, they will always ask the caller if they have obtained or attempted to obtain a Non-Emergency Ambulance Prior Authorization Number (PAN) and will document their efforts as noted by the caller.

MedStar will not decline to send a unit to the requesting facility. However, if the requesting or sending facility fails to obtain an approved authorization (PAN) prior to the transport or within 24 hours of the date of service, the sending facility will be held financially responsible for the transport.

When obtaining a PAN from the Texas Medicaid Health Program (TMHP), please use the attached form which has the following required information already filled in for your convenience. The form includes, the procedure code for the ambulance base rate (A0428), the mileage code (A0425), as well as MedStar Mobile Healthcare's TPI# 088220101 and our NPI#1710981774.

You may submit the PAN on the TMHP website at www.tmhp.com, fax the PAN form to the THMP Ambulance Unit at 1-512-514-4205 or call 1-800-540-0694 Monday through Friday, 7 a.m. to 7 p.m., Central Time. If you are setting up a transfer after hours, the sending facility will be required to obtain the PAN on the next business day and any documentation showing your attempts must be faxed to the MedStar Business Office fax line at 817-632-0537 immediately upon completion of the authorization process.

Medicare Patients:

A Physicians Certification Statement (PCS) is required for all Non-Emergency Medicare transports. MedStar Mobile Healthcare's Call Takers will ask you for this form.

In the event that the attending physician is unable to sign the PCS, one of the following can sign the certification provided they are knowledgeable of the patient's condition and they are employed by either the attending physician or the facility in which the patient is admitted:

1.) Physician Assistant (PA)

2.) Nurse Practitioner (NP)

3.) Clinical Nurse Specialist (CNS)

4.) Registered Nurse (RN)

5.) Discharge planner

As always, MedStar will not decline to send a unit to the requesting facility but the requesting / sending facility must complete the PCS within 48 hours after the transport and forward it to MedStar. In the following instances, regardless of medical necessity, Medicare does not cover:

- Excess mileage for new admits to nursing homes beyond the closest appropriate facility;
- Transports for patient convenience (closer to family, benefit of preferred physician, patient preference, etc.);
- Transports to and from a physician's office.

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For transports lacking medical necessity, the Transport Coordinator should inform the patient and/or family why the transport is not covered and then the Transport Coordinator will need to secure payment prior to transport.

Private Insurance Patients:

It is the responsibility of the sending / requesting facility to verify if prior authorization is required on all Private Insurance patient transfers, (Commercial, PPO, HMO, etc.). This information can be found on the back of the patient's insurance card. If pre-authorization is required, it is the responsibility of the sending / requesting facility to obtain the information and forward this information to MedStar Mobile Healthcare at 817-632-0537. Please use the Texas Standard Form.

Print Form

[Patient Sticker, *if available*]

Physician's Certification Statement for Ambulance Transportation (PCS)

The completed form should be faxed to MedStar Mobile Healthcare at: (817) 632-0537
Communications Center (817) 927-9620 - Business office (817) 923-3700

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date:_____ **(PCS is valid for round trips on this date and for all repetitive trips in the 60-day range.)**

Origin: _____ Destination: _____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

_____

If hosp-hosp transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO **Describe**:_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

2) Is this patient "bed confined" as defined ? ☐ Yes ☐ No - *To be "bed confined" the patient must satisfy all three of the following conditions: (1) unable to get up from bed without Assistance; AND (2) unable to ambulate; AND (3) unable to sit in a chair or wheelchair - Ref. 42 CFR 410.40(d)*

3) Can this patient safely be transported by car or wheelchair (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) In addition to completing questions 1-3 above, please check any of the following conditions that require transport by Ambulance:

☐ Contractures
☐ Danger to self or others
☐ Paralysis (Hemi, Semi, Quad)
☐ Restraints (Physical or chemical) anticipated or used during transport
☐ Requires continuous oxygen or airway monitoring. **Explain**: _____
☐ Patient is **(Circle)**: confused combative lethargic comatose
☐ Cardiac/hemodynamic monitoring required enroute **Explain**: _____
☐ DVT requires elevation of lower extremity
☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling during transport
☐ Unable to maintain erect sitting position in a chair for time needed to transport
☐ Unable to sit in a chair or wheelchair due to decubitus ulcers on buttocks; Grade **(Circle One)**: I II III IV V Ungradable
☐ Morbid obesity requires additional personnel/equipment to safely handle patient. Weight:_____lbs., Height: _____
☐ Special handling/isolation required. **Explain**: _____

☐ Non-healed Fracture
☐ IV Meds/fluids required
☐ Moderate/Severe pain on movement

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

_____ _____

Signature of Physician* or Healthcare Professional **Date Signed**

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.) _____

***Form must be signed only by patient's attending physician for scheduled, repetitive transports.** *For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign* ***(please check appropriate box)**:*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse ☐ Nurse Practitioner ☐ Discharge Planner

Print Form

Physicians Certification Statement for Ambulance Services (PCS)

Repetitive Wound Care Patient

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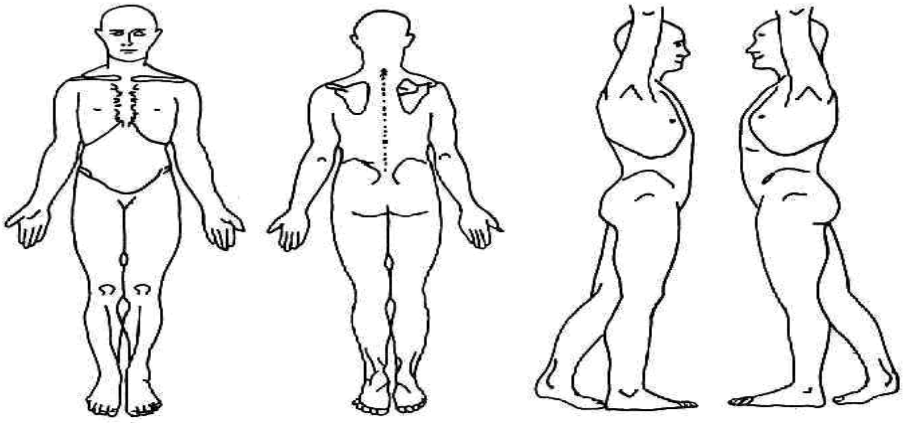
Patient Name:

_____
LAST, FIRST MIDDLE

Date of Birth: ___/___/_____ SSN: _____-___-_____
(MM/DD/YYYY)

Non-emergency Transport – This patient is: (Please Check ALL appropriate fields)

- ☐ Bed-confined, i.e. Unable to do ALL of the following: get up from bed without assistance, ambulate AND sit in a chair, including a wheelchair.
- ☐ Bed-confined due to: Quadriplegic _____ Paraplegic _____ Right side paralysis_____ Left side paralysis _____
- ☐ Bed-confined due to other: (please specify) _____
- ☐ Able to tolerate a wheelchair but is medically unstable due to other conditions indicated in the narrative below
- ☐ Able to tolerate sitting OR allowed to sit for a duration of: _____minutes / hours *(circle one)*
- ☐ Requires cardiac EKG monitoring or IV maintenance
- ☐ Has decubitus ulcers & unable to sit during transportation (Pease be specific to wound(s))
  - ➢ Location_____, stage of decubitus ulcer _____
  - ➢ Duration patient is able to sit in a 24-hour period_____



- ☐ Other Narrative:

_____

_____

_____

Origin: _____City: _____St.: _____ Zip: _____

Destination: _____ City: _____ St.: _____ Zip: _____

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by Medicare or Medicaid to support the determination of medical necessity for ambulance services. I am a representative of the institution named below, which has or will furnish care to the above named patient. By signing below, I acknowledge that the patient was transported from or received by the Institution named below. My signature below may be used by MedStar as part of its documentation to submit a claim to Medicare for its services. By signing this form, neither I nor the institution named below will be held financially responsible for any care or other services provided. This signature is not an acceptance of financial responsibility for the patient.

*****THIS FORM MUST BE SIGNED BY THE ORDERING PHYSICIAN ONLY*****

Physician's Printed Name: _____Title _____NPI: _____

Original Signature of Physician _____ Date signed: _____/_____/_____

Print Form

Physicians Certification Statement for Ambulance Services (PCS)

Repetitive Dialysis Patient

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(817) 632-0537 – Fax

Patient Name:

_____
LAST, FIRST MIDDLE

Date of Birth: ____/____/_____ SSN: _____-____-_____
(MM/DD/YYYY)

Why is transport by ambulance necessary?

Non-emergency Transport – This patient is:

- ☐ Bed-confined, i.e. Unable to do ALL of the following: get up from bed without assistance, ambulate AND sit in a chair, including a wheelchair.
- ☐ Bed-confined due to:
  - ➢ Quadriplegic _____ Paraplegic _____ Right side paralysis_____ Left side paralysis _____
- ☐ Bed-confined due to other: (please specify) _____
- ☐ Able to tolerate a wheelchair but is medically unstable due to other conditions indicated in the narrative below
- ☐ Able to tolerate sitting OR allowed to sit for a duration of: _____ minutes / hours *(circle one)*
- ☐ Unable to self-administer AND requires oxygen due to _____
- ☐ Requires airway monitoring or suctioning
- ☐ Ventilator dependent
- ☐ Requires cardiac EKG monitoring or IV maintenance
- ☐ Heavily medicated/chemically restrained
- ☐ Comatose
- ☐ Has decubitus ulcers & unable to sit during transportation
  - ➢ Location _____, stage of decubitus ulcer _____
- ☐ Other Narrative:

_____

_____

_____

Origin: _____**City:** _____**St.:** _____ **Zip:** _____

Destination: _____**City:** _____ **St.:** _____ **Zip:** _____

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by Medicare or Medicaid to support the determination of medical necessity for ambulance services. I am a representative of the institution named below, which has or will furnish care to the above named patient. By signing below, I acknowledge that the patient was transported from or received by the Institution named below. My signature below may be used by MedStar as part of its documentation to submit a claim to Medicare for its services. By signing this form, neither I nor the institution named below will be held financially responsible for any care or other services provided. This signature is not an acceptance of financial responsibility for the patient.

*****THIS FORM MUST BE SIGNED BY ORDERING PHYSICIAN ONLY*****

Physician's Printed Name: _____Title: _____NPI: _____

Original Signature of Physician _____ Date signed: _____/_____/_____

Transport Coordinator Communication Center (817) 927-9620 fax (817) 817-927-9671

Print Form

Physicians Certification Statement for Ambulance Services (PCS)

Repetitive Patient, Non-Wound Care/Dialysis

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(817) 632-0537 – Fax

Patient Name:

_____
LAST, FIRST MIDDLE

Date of Birth: ____/____/_____ SSN: _____-____-_____
(MM/DD/YYYY)

What service/procedure is requiring **repetitive** transfers?

_____

Why is transport by ambulance necessary?
Non-emergency Transport – This patient is:

- ☐ Bed-confined, i.e. Unable to do ALL of the following: get up from bed without assistance, ambulate AND sit in a chair, including a wheelchair.
- ☐ Bed-confined due to:
  - ➢ Quadriplegic _____ Paraplegic _____ Right side paralysis_____ Left side paralysis _____
- ☐ Bed-confined due to other: (please specify) _____
- ☐ Able to tolerate a wheelchair but is medically unstable due to other conditions indicated in the narrative below
- ☐ Able to tolerate sitting OR allowed to sit for a duration of: _____ minutes / hours *(circle one)*
- ☐ Unable to self-administer AND requires oxygen due to _____
- ☐ Requires airway monitoring or suctioning
- ☐ Ventilator dependent
- ☐ Requires cardiac EKG monitoring or IV maintenance
- ☐ Heavily medicated/chemically restrained
- ☐ Comatose
- ☐ Has decubitus ulcers & unable to sit during transportation
  - ➢ Location _____, stage of decubitus ulcer _____
- ☐ Other Narrative:

_____

_____

_____

Origin: _____**City:** _____**St.:** _____ **Zip:** _____

Destination: _____**City:** _____ **St.:** _____ **Zip:** _____

I certify that the above information is true and correct based on my evaluation of this patient, to the best of my knowledge and professional training. I understand that this information will be used by Medicare or Medicaid to support the determination of medical necessity for ambulance services. I am a representative of the institution named below, which has or will furnish care to the above named patient. By signing below, I acknowledge that the patient was transported from or received by the Institution named below. My signature below may be used by MedStar as part of its documentation to submit a claim to Medicare for its services. By signing this form, neither I nor the institution named below will be held financially responsible for any care or other services provided. This signature is not an acceptance of financial responsibility for the patient.

*****THIS FORM MUST BE SIGNED BY ORDERING PHYSICIAN ONLY*****

Physician's Printed Name: _____Title: _____NPI: _____

Original Signature of Physician _____ Date signed: _____/_____/_____

Transport Coordinator Communication Center (817) 927-9620 fax (817) 817-927-9671

Rev. 05/04/2017

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Non-Emergency Ambulance Prior Authorization Request, Texas Medicaid Program

Checklist:

- ☐ Obtain patient's diagnosis, insurance name and identification number.
- ☐ Call MedStar's Non-Emergency line @ (817) 927-9620
- ☐ Complete *The TMHP Texas Medicaid Form*, below
- ☐ Pull clinical supporting documentation to send with the pre-authorization paperwork
- ☐ Fax pre-authorization paperwork to (512) 514-4205
- ☐ Fax the completed request form and the fax confirmation to MedStar at (817) 632-0537

Texas Medicaid and CSHCN Services Program Nonemergency Ambulance Prior Authorization Request Form Has Been Updated and Is Now Available

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Information posted June 13, 2014

Note: *This article applies to prior authorizations submitted to TMHP for processing. For prior authorizations processed by a Medicaid managed care organization (MCO), providers must refer to the MCO for information about benefits, limitations, prior authorizations, and reimbursement.*

The Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form and instructions have been updated and are now available on this website. Providers may begin using the updated form immediately. Both the updated and previous version of the form will be accepted until August 1, 2014.

Beginning August 1, 2014, requests submitted using the April 2013 version of the form will not be processed and will be returned to the provider for correction.

The Non-Emergency Ambulance Prior Authorization Request form was updated as follows:

- A question was added to the Client Information section of the Request form to determine whether the client is a current inpatient in a hospital facility. A note was added clarifying the responsibility for client transports during an inpatient hospital stay, however, a one-time ambulance transport related to a discharge may be considered for prior authorization.

- Language was added to Item 5 of the Provider Instructions section to clarify transport responsibility for clients who are currently inpatients or whose transport is related to a hospital discharge.

For more information, call the TMHP Contact Center at 1-800-925-9216 or the TMHPCSHCN Services Program Contact Center at 1-800-568-2413.

Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program
Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-512-514-4205

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant Texas Medicaid Provider Procedures Manual and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program
Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-512-514-4205

Requesting Provider Information		
Provider Name:		Date Request Submitted:
TPI or NPI:		Taxonomy Code:
Contact Name:		Ambulance Provider: Metropolitan Area EMS Authority
Phone: (817) 923-3700	Fax: (817) 632-0537	Ambulance TPI or NPI: 088220101

Client Information	
Client Name: (*Last, First, MI*):	
Client Medicaid/CSHCN Number:	Date of Birth:
Is the client morbidly obese? ☐ No ☐ Yes	Client weight (*pounds*):

Are all other means of transport contraindicated? ☐ No ☐ Yes

If "no," this client does not qualify for non-emergency ambulance transport.

If "yes," please complete the remainder of the form.

Reason for Transport:	
Origin:	Destination:
Method of Transport: ☑ Ground ☐ Fixed Wing ☐ Helicopter ☐ Specialized	

Request Type

☐ One-Time, Non-repeating Date:

☐ Recurring Number of days requested: _____ days (2-60 days) Begin Date: _____

Note: *For an exception to the one-time or recurring request type, refer to the Non-emergency Ambulance Exception request in the applicable provider manual, and submit with the Non-emergency Ambulance Exception Request Form.*

Reason for Recurring Transport (2-60 day request type):

☐ Dialysis ☐ Radiation Therapy ☐ Physical Therapy ☐ Hyperbaric Therapy ☐ Other (*explain below*):

_____

Estimated number of visits during these authorization dates: _____

Explain why transport is more cost effective than servicing the client at residence:

_____

Requested Services

HCPCS Procedure Code:	Brief Description of Services:
A0428	Basic Life Support
A0425	Mileage

Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program
Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-512-514-4205

Condition Affecting Transport (Check Each Applicable Condition)

Physical or mental condition affecting transport:

Client requires monitoring by trained staff because:

☐ Oxygen (portable O2 does not apply) ☐ Airway ☐ Suction ☐ Hyperbaric Therapy

☐ Comatose ☐ Cardiac ☐ Life Support ☐ Behavioral

How does the client transfer? ☐ Assisted ☐ Unassisted

Is the client bed-confined (i.e., unable to sit in a chair, stand and ambulate)? ☐ Yes ☐ No

If "No," please indicate the following:

Does the client use an assistive walking device? ☐ Yes ☐ No

Is the client able to stand? ☐ Yes ☐ No

The client is able to sit in which of the following for the duration of the transport:

☐ Chair ☐ Wheelchair ☐ Geri-Chair ☐ Cardiac Chair If able to sit up, for how long: _____

Does the client pose immediate danger to self or others? ☐ Yes ☐ No If "Yes," describe circumstances below:

In addition to ambulance standards, does the client require additional physical restraint? ☐ Yes ☐ No

If "Yes," select the type: ☐ Wrist ☐ Vest ☐ Straps ☐ Other (*describe*): _____

☐ Extra Attendant must be certified by DSHS to provide emergency medical services (*reason*):

☐ Continuous IV therapy or enteral/parenteral feedings* ☐ Advanced decubitus ulcers*

☐ Chemical sedation* ☐ Contractures limiting mobility*

☐ Decreased level of consciousness* ☐ Must remain immobile (i.e., fracture, etc.)*

☐ Isolation precautions (VRE, MRSA, etc.)* ☐ Decreased sitting tolerance time or balance*

☐ Wound precautions* ☐ 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:

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.

Printed Name:

Title: ☐ Physician ☐ Advanced Practice RN ☐ Physician's Assistant ☐ RN ☐ Discharge Planner

Provider Identifier (Medicaid/CSHCN TPI or NPI):

Signature:	Date Signed:

Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program
Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-512-514-4205

Provider Instructions for Non-emergency Ambulance Prior Authorization Request Form

This form must be completed by the provider requesting non-emergency ambulance transportation. [Medicaid Reference: Chapter 32.024(t) Texas Human Resources Code]

All non-emergency ambulance transportation must be medically necessary. Texas Medicaid, CSHCN Services Program, and Medicare have similar requirements for this service to qualify for reimbursement. This form is intended to accommodate all of the programs' requirements. For additional information and changes to this policy and process refer to the respective program information: Texas Medicaid's Provider Procedures Manual, CSHCN Services Program Provider Manual, and Banner Messages; and to Medicare's manuals, newsletters and other publications.

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1. **Requesting Provider Information**—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
2. **Request Date**—Enter the date the form is submitted.
3. **Requesting Provider Identifiers**—Enter the following information for the requesting provider (facility or physician):
   - Enter the Texas Provider Identifier (TPI) number.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
   - Enter the primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
4. **Ambulance Provider Identifier**— Enter the TPI or NPI number of the requested ambulance provider.
5. **Client Information**— This section must be filled out to indicate the client's name in the proper order (last, first, middle initial). Enter the client's date of birth and client number. The client's weight must be listed in pounds. Check yes if the physician has documented that the client is morbidly obese. If a client is currently an inpatient at a hospital facility, any ambulance transports are the responsibility of the hospital. One time ambulance transports that are related to a hospital discharge may be considered for prior authorization.
6. **Requested Services**—Enter the requested Healthcare Common Procedure Coding System (HCPCS) procedure code and a brief description of the requested services. The applicable codes are listed below:

Procedure Codes			
A0382	A0398	A0420	A0422
A0424	A0425	A0426	A0428
A0430	A0431	A0433	A0434
A0435	A0436	A0999	

7. **Client's Current Condition**—This section must be filled out to indicate the client's *current condition* and not to list all historical diagnoses. Do not submit a list of the client's diagnoses unless the diagnoses are relevant to transport (i.e., if client has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to TMHP when reviewing the request form, exactly why the client requires transport by ambulance and cannot be safely transported by any other means.
8. **Details for Checked Boxes**—For questions with check boxes at least one box must be checked. When sections requiring a detail explanation the information must be provided (i.e., if contractures is checked, please give the location and degree of contracture[s]).

9. **Isolation Precautions**—Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.

10. **Request Type**—Check the box for the request type. A One Time, non-repeating request is for a one day period. A Recurring request is for a period of 2-60 days. The provider must indicate the number of days being requested along with the begin date.

11. **Name of Person Signing the Request**—All request forms require a signature, date, and title of the person signing the form. A One Time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the client's condition. A Recurring request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS). The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.

12. **Signing Provider Identifier**—This field is for the TPI or NPI number of the requesting facility or provider signing the form

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(817) 632-0537 – Fax

Amerigroup CHIP/Medicaid Plan (Amerigroup Real Solutions Form)

Checklist:

- ☐ Obtain the patient's diagnosis, insurance name, and ID number
- ☐ Call MedStar Non-Emergency line at 817-927-9620
- ☐ Complete the form on the next page
- ☐ Pull clinical-supporting documentation to send with the Pre-Authorization paperwork
- ☐ Fax Pre-Authorization Paperwork to: 866-249-1271
- ☐ Fax the completed Request Form and Fax Confirmation to 817-632-0537

***Please note: If transport is from ER to ER, an authorization is *NOT* required**

** Amerigroup will also accept the Texas Standardized Form which is included on page 20 of this manual. Only 1 of the form is needed, not both.

Amerigroup
An Anthem Company

https://providers.amerigroup.com

Amerigroup Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-866-249-1271
For behavioral health/intellectual and developmental disabilities services, fax to: 1-866-877-5229

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the prior authorization requirements as stated in the relevant Amerigroup provider manual and TMPPM and they agree and consent to the Certification above .

☐ We Agree

Amerigroup Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-866-249-1271

For behavioral health/intellectual and developmental disabilities services, fax to: 1-866-877-5229

Requesting Provider Information		
Provider Name:		Date Request Submitted:
TPI or NPI:		Taxonomy Code:
Contact Name:		Ambulance Provider: Metropolitan Area EMS Authority DBA MedStar
Phone: (817) 923-3700	Fax: (817) 632-0537	Ambulance TPI or NPI: 1710981774

Member Information	
Member Name: (*Last, First, MI*):	
Member Medicaid Number:	Date of Birth:
Is the member morbidly obese? ☐ No ☐ Yes	Member weight (*pounds*):

Are all other means of transport contraindicated? ☐ No ☐ Yes

If "no," this member does not qualify for non-emergency ambulance transport.

If "yes," please complete the remainder of the form.

Reason for Transport:	
Origin:	Destination:
Method of Transport: ☒ Ground ☐ Fixed Wing ☐ Helicopter ☐ Specialized	

Request Type

☐ One-Time, Non-repeating Date:

☐ Recurring Number of days requested:_____days (2-60 days) Begin Date: _____

Note: *For an exception to the one-time or recurring request type, refer to the Non-emergency Ambulance Exception request in the applicable provider manual, and submit with the Non-emergency Ambulance Exception Request Form.*

Reason for Recurring Transport (2-60 day request type):

☐ Dialysis ☐ Radiation Therapy ☐ Physical Therapy ☐ Hyperbaric Therapy ☐ Other (*explain below*):

_____

Estimated number of visits during these authorization dates: _____

Explain why transport is more cost effective than servicing the member at residence:

_____

Requested Services

HCPCS Procedure Code:	**Brief Description of Services:**
A0428	Base Rate x _____ (# of transports)
A0425	Mileage

Amerigroup Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-866-249-1271

For behavioral health/intellectual and developmental disabilities services, fax to: 1-866-877-5229

Condition Affecting Transport (Check Each Applicable Condition)

Physical or mental condition affecting transport:

Member requires monitoring by trained staff because:

☐ Oxygen (portable O2 does not apply) ☐ Airway ☐ Suction ☐ Hyperbaric Therapy

☐ Comatose ☐ Cardiac ☐ Life Support ☐ Behavioral

How does the member transfer? ☐ Assisted ☐ Unassisted

Is the member bed-confined (i.e., unable to sit in a chair, stand and ambulate)? ☐ Yes ☐ No

If "No," please indicate the following:

Does the member use an assistive walking device? ☐ Yes ☐ No

Is the member able to stand? ☐ Yes ☐ No

The member is able to sit in which of the following for the duration of the transport:

☐ Chair ☐ Wheelchair ☐ Geri-Chair ☐ Cardiac Chair If able to sit up, for how long: _____

Does the member pose immediate danger to self or others? ☐ Yes ☐ No If "Yes," describe circumstances below:

In addition to ambulance standards, does the member require additional physical restraint? ☐ Yes ☐ No

If "Yes," select the type: ☐ Wrist ☐ Vest ☐ Straps ☐ Other (*describe*): _____

☐ Extra Attendant must be certified by DSHS to provide emergency medical services (*reason*):

☐ Continuous IV therapy or enteral/parenteral feedings*

☐ 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 member's other conditions requiring transport by ambulance:

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.

Printed Name:

Title: ☐ Physician ☐ Advanced Practice RN ☐ Physician's Assistant ☐ RN ☐ Discharge Planner

Provider Identifier (Medicaid TPI or NPI):

Signature:	Date Signed:

Amerigroup Non-emergency Ambulance Prior Authorization Request

Submit completed form by fax to: 1-866-249-1271

For behavioral health/intellectual and developmental disabilities services, fax to: 1-866-877-5229

Provider Instructions for Non-emergency Ambulance Prior Authorization Request Form

This form must be completed by the provider requesting non-emergency ambulance transportation. [Medicaid Reference: Chapter 32.024(t) Texas Human Resources Code]

All non-emergency ambulance transportation must be medically necessary. For additional information and changes to this policy and process, refer to the Texas Medicaid Provider Procedures Manual.

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1. **Requesting Provider Information**—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
2. **Request Date**—Enter the date the form is submitted.
3. **Requesting Provider Identifiers**—Enter the following information for the requesting provider (facility or physician):
   - Enter the Texas Provider Identifier (TPI) number.
   - Enter the National Provider Identifier (NPI) number. An NPI is a ten-digit number issued by the National Plan and Provider Enumeration System (NPPES).
   - Enter the primary national taxonomy code. This is a ten-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at www.wpc-edi.com.
4. **Ambulance Provider Identifier**— Enter the TPI or NPI number of the requested ambulance provider.
5. **Member Information**— This section must be filled out to indicate the member's name in the proper order (last, first, middle initial). Enter the member's date of birth and member Medicaid number. The member's weight must be listed in pounds. Check yes if the physician has documented that the member is morbidly obese. If a member is currently an inpatient at a hospital facility, any ambulance transports are the responsibility of the hospital. One time ambulance transports that are related to a hospital discharge may be considered for prior authorization.
6. **Requested Services**—Enter the requested Healthcare Common Procedure Coding System (HCPCS) procedure code and a brief description of the requested services. The applicable codes are listed below:

Procedure Codes			
A0382	A0398	A0420	A0422
A0424	A0425	A0426	A0428
A0430	A0431	A0433	A0434
A0435	A0436	A0999	

7. **Member's Current Condition**—This section must be filled out to indicate the member's *current condition* and not to list all historical diagnoses. Do not submit a list of the member's diagnoses unless the diagnoses are relevant to transport (i.e., if member has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to Amerigroup when reviewing the request form, exactly why the member requires transport by ambulance and cannot be safely transported by any other means.
8. **Details for Checked Boxes**—For questions with check boxes at least one box must be checked. When sections require a detail explanation, the information must be provided (i.e., if contractures is checked, please give the location and degree of contracture[s]).

9. **Isolation Precautions**—Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.
10. **Request Type**—Check the box for the request type. A One Time, non-repeating request is for a one day period. A Recurring request is for a period of 2-60 days. The provider must indicate the number of days being requested along with the begin date.
11. **Name of Person Signing the Request**—All request forms require a signature, date, and title of the person signing the form. A One Time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the member's condition. A Recurring request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
12. **Signing Provider Identifier**—This field is for the TPI or NPI number of the requesting facility or provider signing the form.

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

Amerigroup (MMP) Medicare Plan
(Amerigroup Real Solutions Star+Plus Form)

Checklist:

- ☐ Obtain the patient's diagnosis, insurance name, and identification number
- ☐ Call MedStar non-emergency line at 817-927-9620
- ☐ Complete the form on the next page
- ☐ Pull clinical-supporting documentation to send with the Pre-Authorization paperwork
- ☐ Fax Pre-Authorization Paperwork to 888-235-8468
- ☐ Fax the completed Request Form and Fax Confirmation to 817-632-0537

***Please note: If transport is from ER to ER, an authorization is *NOT* required**

Amerigroup RealSolutions in healthcare

Amerigroup STAR+PLUS MMP
(Medicare-Medicaid Plan)

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice
MMP

Print Clear Form

Precertification request

Phone: 1-855-878-1785 **Fax:** 1-888-235-8468

Today's date_____	**Provider return fax #**_____	
Member information (please verify eligibility prior to rendering service)		
Name (last name, first name): Date of birth:	Amerigroup #:	
Address:		City, State ZIP code:
Medicaid #:	Medicare #:	Other insurance/Workers' Comp:
Referring provider information		
Name:	Office contact name	
Medicaid provider # NPI #:	Amerigroup #:	Group practice #:
Phone #: (817) 923-3700	Fax #: (817) 632-0537	Other phone #:
Specialist consult		
Consultant: *(last name, first name, provider specialty)*		
Amerigroup provider#:	NPI #: Phone #:	Fax #:
Address:		City, State ZIP code:
ICD-10 code/diagnosis/reason for referral:		
PMH/previous studies/treatment:		
Number of visits required:		
Maternity care		
For initial notification of pregnancy, please use the maternity notification form. For all other services related to pregnancy, please use this form (e.g., ultrasound, fetal non-stress test).		
Diagnostic study		
Facility name:		Date of service:
Diagnosis/reason for referral:		
Procedure/CPT-4 code:		
PMH/previous studies/treatments:		
Surgery request		
Surgeon's full name: *(last name, first name)*		Date of service: ____☐ Inpt___☐ Outpt ☐ Ext stay
Facility name:		
Diagnosis/reason for surgery:		
Procedure/CPT-4 code:		
PMH/previous studies/treatments:		
Other - clinical information needed		
☐Durable medical equipment ☐Home health ☐Hospice ☐Other		
Referred to provider: *(last name, first name)* NPI #: 1710981774; Tax ID 75-2234266		Amerigroup provider#:
Diagnosis/reason for referral: ICD 10		
Procedure/CPT-4 code: CPT A0428 (base rate) x _____, A0425		
PMH/previous studies/treatments:		
Place of service: ☐ Office ☐ Home ☐Outpatient hospital ☐ Inpatient hospital ☐ Other Ambulance		
Please attach clinical information to support medical necessity: this referral is valid only for services authorized by this form. Only completed referrals will be processed. If the consultant/provider recommends another service or surgery, additional authorization is required. Certification does not guarantee that benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions.		
To be completed by Amerigroup:	Date approved:	
Date span:	Reference #:	Initials of approver:

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

Texas Standardized Instruction Sheet

Section 1: Add insurance name, fax number and date of request

Section 2: Non-urgent and initial request

Section 3: Patient information (Note: Insurance ID number is required)

Section 4: Facility and contact person information with signature

Section 5: Start date and end date for both lines (Should be date of transport)

- Diagnosis and ICD code required

Section 6: Reason why the ambulance is required and destination of transport.

- After faxing the request with supporting clinical documentation to the insurer, forward all documentation to MedStar (817) 632-0537. Be sure to include the Fax Confirmation receipt.

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

Preauthorization Contact List

1. The following insurance companies will accept the Texas Standardized Form
2. After faxing to the plan; fax the authorization form to MedStar at 817-632-0537

Insurance Name	Phone Number	Fax Number
Ambetter	1-877-687-1196	1-855-537-3447
Anthem Blue Cross MMP	855-878-1785 ext. 35278	888-235-8468
Blue Cross Blue Shield	# On Insurance Card	Must Call Plan
Care N Care	855-359-9999	888-965-1964
Medicaid - Blue Cross BS	1-888-292-4487	855-879-7180
Medicaid - Cook / CHIP Cook	800-862-2247	682-885-8402
Medicaid - Driscoll	877-324-3627	866-741-5650
Medicaid - First Care	800-431-7798	800-248-1852
Medicaid - Healthspring	877-562-4402	877-809-0787
Medicaid - Molina	866-449-6849	866-420-3639
Medicaid - Parkland	800-306-8612	800-240-0410
Medicaid - RightCare Scott & White	855-897-4448	512-383-8703
Medicaid - Superior	877-391-5921 ext. 42191	800-690-7030
Medicaid - United Health Community	866-331-2243	877-940-1972
Medicaid Aetna/CHIP Aetna	800-306-8612	866-835-9589
Medicare - Aetna	800-624-0756	Must Call Plan
Medicare - Superior MMP	800-218-7508	844-560-8993
Medicare - Healthspring	800-280-8888	Must Call Plan
Tricare Prime	800-444-5445	877-548-1547
Wellcare	855-538-0454	877-894-2034

If the patient's plan does not appear on this list it does not mean that a preauthorization is not needed. It simply means that we do not have the contact information for that payor. It is recommended that, before a nonemergency transfer is scheduled, that the sending facility contacts the healthcare plan to determine if a preauthorization is needed.

Rev. 02/07/2018

Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0415 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. ***Do not send this form*** *to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.*

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: Use this form to request authorization **by fax or mail** when an issuer requires prior authorization of a health care service. An Issuer may also provide an **electronic version of this form** on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:

Section I – Submission:
An issuer may have already entered this information on the copy of this form posted on its website.

Section II – General Information:
Urgent reviews: Request an urgent review for a patient with a life-threatening condition, **or** for a patient who is currently hospitalized, **or** to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI – Clinical Documentation:
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

Note: *Some issuers may require more information or additional forms to process your request. If you think more information or an additional form may be needed, please check the issuer's website before faxing or mailing your request.*
Note: *If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Print Clear Form

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent		Clinical Reason for Urgency:	
Request Type: ☐ Initial Request ☐ Extension/Renewal/Amendment		Prev. Auth. #:	

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name: Area Metro d/b/a MedStar; Tax ID: 75-2234266	
NPI #:	Specialty:	NPI #: 1710981774	Specialty: Ambulance
Phone:	Fax:	Phone: (817) 923-3700	Fax: (817) 632-0537
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code
Base Rate	A0428 (BLS)				
Mileage	A0425				

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☐ Mental Health/Substance Abuse

Number of Sessions:_____ Duration:_____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration:_____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) (Medicaid Only: Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

Clear Form Print

Ambulance Transportation Estimate

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

****Include a Face Sheet when faxing****

Patient Name: _____
LAST, FIRST MIDDLE

Date of Birth: ____/____/_____ SSN: _____-____-_____
(MM/DD/YYYY)

Requestor: _____ Title: _____

Phone: _____ Fax: _____

Origin: _____ Destination: _____

Address: _____ Address: _____

Unit & Room: _____ Unit & Room: _____

City, St, ZIP: _____ City, St, ZIP: _____

Date of Service: _____ Ph. Number: _____

Pickup Time: _____ ☐ AM ☐ PM Round Trip? ☐ Yes ☐ No

MedStar Mobile Healthcare Estimated Cost: $_____ (each way)
Please call the Communications Center @ (817) 927-9620 for an estimate.

MedStar Mobile Healthcare may only provide an estimated cost. Additional fees may be charged for wait times at a rate of $1.50 per minute. For a full fee schedule, please contact our Business Office at the above number during normal business hours. The law requires mileage be billed in accordance with odometer readings indicating the actual mileage traveled with the patient from origin to destination.

By signing this document, you are guaranteeing that the facility indicated will be financially responsible for the final cost of the non-emergency ambulance service as listed above and that you are authorized to guarantee payment on behalf of the facility.

Facility to Be Billed: _____

Billing Address: _____

City, State, ZIP: _____

Phone Number: _____

_____ _____
Printed Name of Authorizing Representative Title

_____ _____/_____/_____
Signature of Authorizing Representative Date

[*Patient Sticker Here*]

Rev. 07/25/2017

Medical Records Request

Metropolitan Area EMS Authority
2900 Alta Mere Drive
Fort Worth, Texas 76116
www.MedStar911.org
911 – Emergency
(817) 927-9620 – Communications Center
(817) 923-3700 – Business Office
(817) 632-0537 – Fax

To request medical records:

1. Contact MedStar Mobile Healthcare, Medical Records Department
    a. (817) 923-3700, EXT. 261 or
    b. MedicalRecords@MedStar911.org
        i. Any request made via email must originate from an institutional email address.
2. Provide:
    a. Patient Name
    b. Date of Birth
    c. Last 4 of Social Security Number, if available.
    d. Date of Service

- Please allow for 3-4 business days for processing. If a rush request is needed, please notify us ASAP and we will make every effort to provide expedited service