



# 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:** \_\_\_\_\_

**Provider TPI:** \_\_\_\_\_ **NPI:** \_\_\_\_\_ **Taxonomy:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Ambulance Provider Name:** \_\_\_\_\_

**Ambulance Provider Identifier:** \_\_\_\_\_

### 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:** \_\_\_/\_\_\_/\_\_\_\_\_

## Provider Instructions for Nonemergency Ambulance Prior Authorization Request Form

All nonemergency ambulance transportation must be medically necessary. Texas Medicaid and Medicare have similar requirements for this service to qualify for reimbursement. This form is intended to accommodate both programs' requirements. The criteria for determining medical necessity include: the client is bed-confined and other methods of transportation are contraindicated, or the client's condition is such that transportation by ambulance is medically required. For additional information and changes to this policy and process refer to the respective program information: Texas Medicaid's Provider Procedures Manual, bulletins and Banner Messages; and to Medicare's manuals, newsletters and other publications.

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1. **Request Date**—Enter the date the form is submitted.
2. **Requesting Provider Information**—Enter the name of the entity requesting authorization. (i.e., hospital, nursing facility, dialysis facility, physician).
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](http://www.wpc-edi.com).
4. **Ambulance Provider Identifier**— Enter the TPI or NPI number of the requested ambulance provider. If the ambulance provider changes from the provider you originally requested, notify TMHP of the new provider by phone (1-800-925-9126, Option 3) or fax (1-512-514-4205).
5. **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.
6. **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.
7. **Details for Checked Boxes**—For each checked answer, a detailed explanation is required (i.e., if contractures is checked, please give the location and degree of contracture[s]). If a client has a decreased tolerance for sitting time, please indicate why the client has a decreased tolerance as well as the maximum length of time the client is able to sit upright. Additional documentation can be submitted with this request form if needed.
8. **Request Type**—Check the box for the request type. A One Time, non-repeating request is for a one day period. A Short Term request is for a period of 2-60 days when repeated transports are expected to occur; both Medicaid and Medicare permit short-term requests. A Long Term request is for a period of 61-180 days when repeated transports are expected to occur; Medicare does not permit a Long Term request. Medicaid requires a physician signature for Short Term and Long Term requests. Enter the begin and end dates of the authorization period for short and long-term requests.
9. **Transport Time**—This field must be filled out for all hospital discharge requests. The anticipated time of transport must be entered in order to ensure the request was initiated prior to the actual time of transport.
10. **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 request of a Short Term or Long Term authorization period must be signed and dated by the physician. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
11. **Signing Provider Identifier**—This field is for the TPI or NPI number of the requesting facility or provider signing the form. The signature must be dated no earlier than 60 days prior to the transport.