



**REQUEST FOR TRANSPORTATION**

**DATE:** \_\_\_\_\_

<p><b>1A.</b> IEHP covers ambulance and other medical transportation only when ordinary public or private conveyance is medically contraindicated <u>and</u> transportation is required for obtaining needed medical care.</p> <p>Can Member be transported by taxi, bus or personal car?  <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
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<p><b>1B. Other Referrals</b></p> <p><b>AUTH/TRACKING NUMBER:</b> _____</p> <p><b>AUTH/EXPIRATION DATE:</b> _____</p>
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**2. GENERAL INFORMATION**

<b>Member Name</b> (please print)	<b>DOB</b>	<b>ID #</b>
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<b>Diagnosis:</b>	<b>Length of time medical transportation is required:</b>
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**Clinical Justification for Request** (When transportation is requested for an ongoing basis, the chronic nature of the recipient's medical or physical condition must be indicated and a treatment plan from the physician must be included. A diagnosis alone, will not satisfy this requirement).

<b>Requesting Physician Signature</b> (Required)	<b>Phone</b>	<b>Fax</b>
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**3. COMPLETED BY IEHP**

<b>Date Additional Information Requested</b>	<b>Date Approved</b>	<b>Date Modified</b>	<b>Date Denied</b>
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**Medical Reviewer Comments**

<b>Medical Reviewer Signature</b>	<b>Date</b>
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Fax completed referral forms to (909) 890-5528

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