INLAND EMPIRE HEALTH PLAN

*Required Field

TRANSPORTATION REQUEST FORM (HOSPITAL)

Today's Date: _____ **Discharge Date/Time:** _____

Member Name: _____

IEHP Member ID: _____ *** Height:** _____ *** Weight:** _____

Trach to Ventilator: ☐ Yes ☐ No **Suctioning:** ☐ Deep ☐ Mild ☐ Shallow

Oxygen: ☐ Yes ☐ No Liter Flow: _____ Comments: _____

** Height and weight only required if Member is transported via wheelchair or gurney.*

COVID-19 TEST DATA

Test Administered: ☐ Yes ☐ No ☐ Unknown **Test Date:** _____ **Result Date:** _____

Test Results: ☐ COVID-19 Positive ☐ COVID-19 Negative ☐ Unknown

TRANSPORTATION FROM

Facility & Treating Physician: _____ **Room#:** _____

Address: _____

City: _____ **ZIP:** _____

Contact Person: **Phone:**

TRANSPORTATION TO HOME

Facility (if applicable):

Receiving Dr./Caregiver _____ **Room#:** _____

Address: _____ **Phone:**

City: **ZIP:**

FOLLOW UP APPOINTMENTS

☐ Dialysis ☐ Chemotherapy/Radiation ☐ Other: _____

Appointment Date: _____ Dialysis Days: _____

Appointment Time: Start Date: Chair Times:

TRANSPORTATION BY

☐ Ambulatory

☐ Wheelchair ☐ Vendor to provide wheelchair (NOTE: Gurney will be provided when no W/C availability)

☐ Bariatric ☐ Standard Wheelchair ☐ Wide Wheelchair ☐ Electric Wheelchair

☐ Gurney ☐ ALS ☐ BLS ☐ CCT (only) ☐ Bariatric

☐ Attendant/Caregiver Sending Dr.

Receiving Dr./Caregiver

Please fax request to **IEHP UM Transportation Department (909) 912-1049**

P.O BOX 1800 Rancho Cucamonga CA 91729-1800
Phone: (951) 374-3441 Fax: (909) 912-1049
Visit our web site at: www.iehp.org
A Public Entity

Revised: 08/17/2020