WASHINGTON COUNTY AMBULANCE SERVICE
~ Est. 1968 ~

NON-EMERGENT AMBULANCE TRANSPORT REQUEST

**** OBTAIN A COMPLETED PCS PRIOR TO TRANSPORTING****

GENERAL INFORMATION

Requsted by:	*Call Back #:*

TRANSFER INFORMATION

Transfer Time:	*Transfer Date:*
Pickup Location:	*Destination Name:*
Room:	***PCS Completed?*** □ Yes □ Will be completed prior to Pickup

PATIENT INFORMATION:

COVID Status: □ Negative □ Positive

Name:			
DOB:		*Age*	*Gender* □ Male □ Female
Weight:	*Height:*		
Address:			
City:	*State:*	*Zip:*	
Patient Phone #:			
Medical Necessity (reason for ambulance transfer):			
Special Needs (if any): □ Oxygen ___ lpm □ Suctioning □ Bariatric Other:			

BILLING

Payer:

□Insurance Medicare A& B Blue Cross Blue Shield Cigna Aetna Humana (Any Major Insurance)	□ Private Pay (Accept Check)	□Hospice (ensure pt is on hospice prior to transfer) Hospice Nurse Should Sign PCR	□Hospital (obtain a letter detailing transport information and date with hospital agreeing to payment)

PLEASE CALL BILLING OFFICE IF THE PATIENT HAS:

Medicaid (Iowa Total Care, IME, Amerigroup)

Staff Signature: _____

Time/Date of Request: _____