

- ☐ APPROVED  
☐ INCOMPLETE - Resend  
☐ DENIED - Reason:

### PROVIDER REQUEST FOR TRANSPORTATION SERVICES

THIS FORM IS ONLY FOR DISCHARGES DURING NORMAL  
BUSINESS HOURS M-F 8AM TO 5 PM. PLEASE ALLOW 3  
HOURS FOR TRANSPORTATION SERVICES  
FOR AFTER HOURS DISCHARGES  
PLEASE CALL: 855-264-6368

**First Transit**  
Colorado NEMT  
13111 East Briarwood Avenue, Suite 260  
Centennial, CO 80112  
Line: 855.264.6368  
Fax: 303.790.4386  
[www.medicaidco.com](http://www.medicaidco.com)

#### Requesting Organization Information

Your Organization Name: \_\_\_\_\_ Today's Date/Time: \_\_\_\_\_ AM PM  
 Your Name: \_\_\_\_\_ Title/Relationship: \_\_\_\_\_  
 Your Fax Number: \_\_\_\_\_ Your Telephone Number: \_\_\_\_\_

#### Client Information:

Client Name: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_  
 (Last) (First) Date of Birth: \_\_\_\_\_

#### Trip Information

Origin	Destination
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Location Name: _____ Room # _____	Location Name: _____ Room # _____
Location Telephone #: _____	Location Telephone #: _____
Physician Name _____	

#### Schedule - please complete ONLY one section

Trip Reason (Be Specific):   Preferred Provider: _____ 1 <sup>st</sup> Transit cannot guarantee the preferred provider	<b>Additional Equipment</b>  Check all that apply:  Oxygen <input type="checkbox"/> _____ LPM Monitor <input type="checkbox"/> Advanced Airway <input type="checkbox"/> 72hr MHH <input type="checkbox"/> IV Meds <input type="checkbox"/> Special Precautions <input type="checkbox"/>  Other (Describe): _____
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#### Transport Mobility Needs - (Please select the medically most appropriate mode of transportation that will meet the client's needs)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>Ambulatory</b> - Includes all modes of transportation from personal vehicle to public transportation and paratransit services. | <input type="checkbox"/> <b>Wheelchair</b> - Includes standard and electric wheelchairs and three wheeled scooters. | <input type="checkbox"/> <b>Non-Emergency Ambulance</b> - please note support level required:<br>_____ BLS _____ ALS |
|--|---|--|

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Signature of Requesting Person

Date Signed

REV 5/11/13

# Emergency Room Discharge Papers Sample

**M Mosston**



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