Reset Form

NON-EMERGENT FIXED WING AIR AMBULANCE PRIOR AUTHORIZATION REQUEST FORM

FYI: ***Incomplete, illegible, or inaccurate forms will be returned to the sender.*** Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request.

Fax form and relevant clinical documentation to:
612-884-2499 or 1-866-610-7215

For questions, call:
612-676-3300 or 1-888-531-1493

E-Mail: HCM_Fax@ucare.org
UCare's Secure E-mail Site

***No prior authorization is required for emergent transportation**

PATIENT INFORMATION:		
Name:		
Member ID:	PMI:	
Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	
Member Health Plan (required)*:		

ORDERING PRACTITIONER/CLINIC INFORMATION:		
Ordering Practitioner Name:	Clinic NPI Number:	
Clinic Name:		
Ordering Practitioner Address:		
City:	State:	Zip Code:
Phone:	Fax:	

SERVICING PROVIDER INFORMATION:		
Servicing Provider Clinic Location Name (required)*:		
Provider Location NPI Number (required)*:		
Provider Location Address:		
City:	State:	Zip Code:

CONTACT PERSON FOR PRIOR AUTHORIZATION QUESTIONS:	
Name:	
Phone:	Fax:
Email:	

CPT/HCPC:		
CPT/HCPC Codes	# of Units	Date of Service
A0430		
A0435		

CURRENT FACILITY INFORMATION:		
Facility Name:	NPI Number:	
Facility Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	

RECEIVING FACILITY INFORMATION:		
Facility Name:	NPI Number:	
Facility Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	

CLINICAL REASON FOR AIR AMBULANCE NECESSITY:

- ☐ Burn
- ☐ Cardiac
- ☐ Neonatal
- ☐ Neurological
- ☐ Psychiatric inpatient
- ☐ Respiratory
- ☐ Trauma
- ☐ Other_____

MEMBER REQUIRES MONITORING BY TRAINED STAFF BECAUSE:

- ☐ Oxygen (portable O2 does not apply)
- ☐ Comatose
- ☐ Cardiac
- ☐ Airway
- ☐ Life support
- ☐ Suction
- ☐ Behavioral
- ☐ Hyperbaric therapy
- ☐ Other:_____

Explain the specialty care the member will receive at the accepting facility, that can't be provide where the member is currently receiving care (required)*:

PLEASE SELECT STANDARD OR EXPEDITED REQUEST BELOW

Please select and complete one option below (STANDARD REQUEST or EXPEDITED REQUEST).

◯ STANDARD REQUEST

- Medicare and Medical Assistance decision within 10 business days.
- IFP decision within 5 business days.

◯ EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review time-frame would potentially jeopardize the member's health, life, or ability to regain function.
- Medicare and Medical Assistance decision within 72 hours.
- IFP decision within 48 hours, including 1 business day.
- Billing and retrospective authorizations are not expedited.

1. Proposed date of service: _____
   - Billing and retrospective authorizations are not expedited.
2. Clinical reason for urgency (unrelated to scheduling issues):
3. Provide a contact name and number available for this request:
   - Due to the expedited processing time, please ensure that the designated contact is readily accessible should further information be required.

CONFIRM AND COMPLETE THE REQUIRED STEPS TO PROCEED:

☐Clinical notes supporting any of the above have been included in the submission form.
(Incomplete submission can delay decision time)

Physician/Practitioner Signature _____ Date _____