

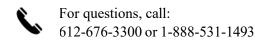


NON-EMERGENT FIXED WING AIR AMBULANCE PRIOR **AUTHORIZATION REQUEST FORM**

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



E-Mail: HCM Fax@ucare.org

UCare's Secure E-mail	Site *No pri	or authorizatio	n is required for emergent transportation
PATIENT INFORMATIO	N:		
Name:			
Member ID:		PMI:	
Address:			
City:		State:	Zip Code:
Date of Birth:		Phone:	
Member Health Plan (required)	*:		
ORDERING PRACTITIO	NER/CLINIC INFO	RMATION:	
Ordering Practitioner Name:			Clinic NPI Number:
Clinic Name:			
Ordering Practitioner Address:			
City:		State:	Zip Code:
Phone:		Fax:	
SERVICING PROVIDER			
Servicing Provider Clinic Locat			
Provider Location NPI Number	(required)*:		
Provider Location Address:			
City:		State:	Zip Code:
CONTACT PERSON FOR	PRIOR AUTHORI	ZATION QUI	ESTIONS:
Name:			
Phone:		Fax:	
Email:			
СРТ/НСРС:			
CPT/HCPC Codes	# of Units		Date of Service
A0430			
A0435			
ЛОТЭЭ			
CURRENT FACILITY IN	FORMATION:		
Facility Name:			NPI Number:
Facility Street Address:			TILL I TOURISON.
City:		State:	Zip Code:
Phone:		Fax:	1.1p 3000.

RECEIVING FACILITY INFORMATION:					
Facility Name:	NP	NPI Number:			
Facility Street Address:					
City:	State:	Zip Code:			
Phone:	Fax:				
CLINICAL REASON FOR AIR AMBULANCE	NECESSITY:				
	☐ Psychiatric inpatier	nt			
	☐ Respiratory				
☐ Neonatal	☐ Trauma				
☐ Neurological [Other				
MEMBER REQUIRES MONITORING BY TR	AINED STAFF BI	ECAUSE:			
☐ Oxygen (portable O2 does not apply)	☐ Suction				
11 07	☐ Behavioral				
☐ Cardiac [☐ Hyperbaric therapy				
	☐ Other:				
☐ Life support					
Explain the specialty care the member will receive		g facility, that can't be provide			
where the member is currently receiving care (r	equirea)":				
PLEASE SELECT STANDARD OR EXPEDIT	ED REOUEST BE	LOW			
	<u> </u>				
Please select and complete one option below (S'	TANDARD REQU	JEST <u>or</u> EXPEDITED REQUEST).			
		<u> </u>			
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		ew 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. 					
	, d110 d1				
 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 en	sure that the designate	ed contact is readily accessible should			
further information be required.					
CONFIRM AND COMPLETE THE REQUIRE	D STEPS TO PRO	OCEED:			
Clinical notes supporting any of the above have been included in the submission form.					
(Incomplete submission can delay decision time)	meraded in the subili	1551011 101111.			
(moonpiece sacrinission can delay decision time)					
Physician/Practitioner Signature		Date			