******MEDI/MEDI******

PA#_____

Medicaid Ambulance Review
Prior Authorization

Date:_____ Caller Name:_____ Phone:_____
Time: _____ Dept._____

Client Information

Participant Name:_____ Date of Birth:_____

Medicaid ID Number_____
Eligibility Verified? Yes / No Medicare or Other Insurance: Yes / No Type:_____

Provider Information

Ambulance Provider:_____Contact:_____

Transport Information

Transfer Date:_____Time:_____ LOS Required: **BLS / ALS / Spec/Neo**

Pick up Point:_____ Destination:_____

Dis Physician: _____Rec. Physician: _____

Admit Date: _____

Dx:_____

Medical Reason for TX:_____

Temp:_____R:_____B/P:_____ P: _____ SPO2:_____ BG:_____ WT: _____

Notes:_____

_____

_____

_____

Previous HX:_____

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