

**Idaho Medicaid Non-Emergent Medical
Transportation Request Form**

*Return to: Medicaid Transportation Unit
Fax: (800) 296-0513 Phone: (800) 296-0509
Mail: PO Box 83720, Boise, ID 83720-0036*

Please complete the entire form

| Medicaid Provider Information | | | |
|--|---|--|--|
| Provider Name: | Provider Number: | Phone: | Fax: |
| Medical Provider Treatment Address: | | Physician Referral Obtained of Service is Outside Community <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Medicaid Participant Information | | | |
| Last Name: | First Name: | Initial: | Medicaid ID: |
| Phone Number: | Participant Address: City: State: Zip: | | |
| Why Not Driving Self (Friend, Family, Organization): | | | |
| Medical Services/Reason for Transport: | | | |
| Special Transport Needs (Wheelchair, Van): | | Participant's Healthy Connections Doctor (if applicable): | |
| Transport Information | | | |
| Dates of Service: From: To: | Appointment Time: | Initial Blanket Authorization: <input type="checkbox"/> Yes <input type="checkbox"/> No Days of the Week: | |
| Pick-Up Address: | | Drop Off Address (End of Transport): | |
| Total One Way Miles Per Trip: | | | |
| Services Requested | | | |
| Procedure Codes Requested: | Units Requested Per Code: | Price Per Unit: | |
| Notes: | | | |
| Medicaid Use Only (Do not Write in Area Below) | | | |
| <input type="checkbox"/> Approved <input type="checkbox"/> Denied | DB Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No | | PA Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No |