ALLIANCE AMBULANCE, INC
Ambulance Transfer Worksheet

Patient Name ____ Service Date ______/ _______ / ______

From ______________________________ To ____________________________ Roundtrip [ ]yes [ ]No

1) The patient is being transported for
[ ] Discharge – reason for hospital stay
____
[ ] Patient convenience / preference only – **explain below**
[ ] For higher level care
[ ] This is the closest appropriate facility to treat patient
[ ] This is the closest appropriate facility to treat patient with beds available
[ ] Cardiac Catheterization – **explain below** why it cannot be done at current facility
[ ] Extended in-patient mental health services unavailable at current facility
[ ] Local specialist is unavailable to provide needed treatment – **explain below**
[ ] Complicated patient – **explain below**
[ ] Other – **explain below**
Explanation:
____

2) Continuing Medical Condition at time of transport that necessitates ambulance
[ ] Needs continuous oxygen – **give reason**
____
[ ] Needs restraints – **explain below**
[ ] Has unset or in-operable fracture – **explain below**
[ ] Has orthopedic or other device – must stay immobile – **explain below**
[ ] Patient was sedated prior to transport
[ ] Other – **explain below**
Explanation:
____

3) Physical Condition at time of transport that necessitates ambulance transport
[ ] Bed confined – means *unable to get up from bed without assistance, **and** *unable to ambulate **and** *unable to sit in a chair or wheel chair
Mark any that apply
[ ] Contracted
[ ] Unaware of self
[ ] no purposeful movement
[ ] Fetal Position
[ ] Bed Sores
[ ] Other _____________________
[ ] Patient is very weak – **explain below**
[ ] Patient has extreme pain – **explain below**
[ ] Patient cannot support self in sitting position for length of transport
[ ] Patient is danger to self or others
[ ] Patient has decreased level of consciousness – needs monitoring
[ ] Other – **explain below**
Explanation:
____

4) Insurance and payment information
[ ] Patient has Medicare B
[ ] Patient has Medicaid (traditional) -**Give information below**
[ ] Patient has private insurance – non-HMO
[ ] Patient has Medicare HMO-**Give information below**
[ ] Patient has Medicaid HMO-**Give information below**
[ ] Patient is under hospice care
[ ] Patient is a veteran – contact VA travel department
[ ] Patient or family is paying for transport
[ ] Facility is paying for transport

Insurance/HMO Name:
____

Authorization number or contact name:
____

The attending physician must sign this form. If the physician is unavailable 42 CFR 410.40 (d)(3)(iii) allows this form to be signed by either a physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner who has personal knowledge of the beneficiary's condition at the time of ambulance transport.

Attending physician and UPIN number:
____

Name of person completing form:
____

Signature of person completing form:
____

Medicare HMOs
Texan Plus (888) 800-0760
Texas Healthsprings (832) 553-3300

Medicaid and Medicaid HMOs
Amerigroup (713) 218-5100
Evercare (713) 778-8600
Community Health Choice (713) 746-6994
Texas Children's CHIP (832) 828-1042
Texas Health Network (888) 834-7226
TMHP (Medicaid) 800-925-9126

Please complete and give copy to ambulance crew at time of pick-up.
Call (713) 682-2273 if you have any questions