NON-EMERGENT AMBULANCE TRANSPORT REQUEST

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Email: info@wcas-iowa.org	

WASHINGTON COUNTY AMBULANCE SERVICE
~ Est. 1968 ~

A PCS MUST BE OBTAINED PRIOR TO TRANSPORT

GENERAL INFORMATION

Requested by:		*Call Back Phone:* Floor Call Back Number:
Transfer Time:		*Transfer Date:*
Origin:	*Room:*	*Destination:* *Address:*

Medical necessity/reason for ambulance transfer: □ BLS □ ALS

□ Oxygen @ ____lpm via _____ □ Cardiac Monitor □ Medications (IV) □ Suction □ Bariatric

Other:

PATIENT INFORMATION

Name:	*DOB*	*Age:*	*Gender:* □ **Male** □ **Female**
Weight:	*Height:*	*Phone:*	
Address, City, State, Zip:			
ABN: □ *Yes* □ *No*			

BILLING INFORMATION

Over 60 Miles complete ABN or Guarantee Pay.

○ Insurance		○ Hospital	○ Hospice	○ Private Pay
Accepted	***Not Accepted***	(You must obtain a letter (Fax or Email) detailing transport information and date with hospital agreeing to payment. Must include name, title & Hospital or Agency)	(ensure pt is **on hospice prior to transfer**) Hospice Nurse Should Sign PCR if available.	A.B.N. must be filled out/completed. Milage...$22/mi BLS.....$800.00 ALS.....$1,200.00
○Medicare A&B	Medicaid			
○BC/BS	United Health			
○Cigna	Amerigroup			
○Aetna	Iowa Total Care			
○Humana				

Is the patient a current resident of Washington County? □ **Yes** □ **No**	*Discharge Papers Ready by Time of Transport?* □ Yes □ Will be completed prior to Pickup	*Covid Status:* □ - □ + □Vaccinated

Area for Office Completion

□ **Transfer Accepted** Transfer Staff: _____ & _____ A-_____

□ **Transfer Declined** *Reason:* □ *Payment* □ *No Avail. Staff* □ *No Avail Unit* □ *Other:*_____

Received by (Print): _____

Date Requested _____/_____/_____ Time Requested: _____