BlueCross BlueShield of Mississippi
Committed to a Healthier Mississippi.

Attn: Care Management
Telephone: 800-841-9659
Fax: 800-348-3804
www.bcbsms.com

MEDICAL TRANSPORT PRIOR APPROVAL REQUEST

GENERAL INFORMATION

Patient's Blue Cross & Blue Shield of Mississippi ID #: _____

Patient Name: _____ Date of Birth: _____

Billing Provider Name: _____ Billing BCBS of MS Provider #: _____

Provider NPI Number: _____ Provider E-mail: _____

Provider Address: _____

Phone Number: _____ Fax Number: _____

Type of Request:
☐ Ground Transportation ☐ Air Transportation ☐ Emergency ☐ Non-emergency

Date transportation needed: _____

Originating Location:
☐ Acute care hospital ☐ Inpatient Rehab Facility ☐ Long Term Acute Care Facility ☐ Skilled Nursing Facility
☐ Home ☐ Other _____

Facility Name: _____ Facility Location: _____

Final Destination:
☐ Acute care hospital ☐ Inpatient Rehab Facility ☐ Long Term Acute Care Facility ☐ Skilled Nursing Facility
☐ Home ☐ Other _____

Facility Name: _____ Facility Location: _____

REASON FOR TRANSPORTATION

Diagnoses: _____

Functional impairments that support use of requested mode of transportation:
☐ Confined to bed ☐ Requires reclining position ☐ Other _____

Clinical condition of the patient requiring the requested mode of transportation: _____

Is monitoring by medical professionals required during transport? ☐ Yes ☐ No

Does the patient require life-sustaining equipment during transport? ☐ Yes ☐ No

Will the patient require use of oxygen during transport? ☐ Yes ☐ No

Anticipated medical services to be provided during transportation:
☐ IV therapy ☐ Ventilator management ☐ Oxygen saturation monitoring ☐ Telemetry ☐ Suction
☐ Other _____

FACILITY TO FACILITY TRANSFER

Is request for a facility to facility transfer? ☐ Yes ☐ No

Reason for transfer:
☐ Higher level of care needs by the patient ☐ Current facility unable to provide required services
☐ Transfer to inpatient rehab facility, skilled nursing facility, etc.
☐ Other: _____

Is the facility of final destination the nearest facility that can meet the patient's needs? ☐ Yes ☐ No

Describe services that cannot be provided at the current facility that are needed by the patient:

_____

_____