UH Care Coordination Department
Ambulance or Wheelchair Coach Special Service Budget
Authorization Form

Last Name:_____

First Name:_____

Medical Record:_____

Unit/Room#:_____

Requested by:_____

**SOCIAL WORK/CASE MANAGER**

Approved by (if more than $100):_____

**MANAGER/DIRECTOR**

Transportation Provider: _Pulse Medical Transportation_____

Service Level Required (circle one) ☐ Wheelchair Transport ☐ Ambulance Transport ☐ Specialty Care Unit Transport

Destination: From UH to _____

_____

Approximate One-Way Mileage: _____ Approximate Cost of Transport: _____

**Reasons why UH is paying for this transport:**

☐ Patient is indigent or has no insurance coverage

Name of Insurance Carrier:_____

☐ Patient insurance does not cover this type of transport

☐ Medicaid Pending

☐ Other please explain:_____

_____

_____

Person completing form (Please Print):_____

Time: _____

Date: _____

## Please give Completed Forms to Tawanda Sheard, B213