PULSE MEDICAL TRANSPORTATION

• Phone: (443) 501-3939 • Fax: (443) 501-3950 •

If not covered by insurance, responsible party:

☐ FACILITY ☐ PATIENT

Date of Transport:___/___/____ **Apt Time:** _____ **Mode of Transportation**: VENT WC STRETCHER BARI WC BARI STRETCHER

ALL STRETCHER TRANSPORTS MUST HAVE A PHYSCIAN CERTIFICATION STATEMENT (PCS) FOR EVERY TRANSPORT
WE WILL NOT ACCEPT FUTURE TRANSPORTS MORE THAN 30 DAYS OUT

Facility Name:_____ Room Number:_____ Your Name:_____

Patient's Last Name: _____ First Name:_____ Sex: **M F**

SSN: _____ DOB: ____/____/_____ Weight _____lbs. Date last weighed: _____

Responsible Party Name: _____ Relation: _____ Phone #: _____

Address: _____ City: _____ St: _____ Zip: _____

Destination Facility Name:		Does the office accommodate stretchers?: **Y N**
Address:		City:
Building Name:	Ste/Dept:	Zip:
Phone Number:	Doctor's Name:	Length of apt:

Going For:(Check box that applies)

☐ Dental		☐ Pain Management	
☐ CT Scan	☐ Wound Care	☐ Orthopedic	☐ Neurology
☐ X-Ray	☐ MRI	☐ Dexa Scan	☐ Infectious Disease
☐ Oncology	☐ Dialysis	☐ Cardiology	☐ Urology
☐ Ophthalmology	☐ Radiation	☐ G.I.	☐ Vascular
☐ Endocrinology	☐ Chemo	☐ ENT	☐GYN
☐ Podiatry	☐ Hyperbaric	☐ Other:_____	

Reason for Appointment: _____

Description of patients past medical history/diagnosis': _____

_____

Oxygen: _____ LPM Vent Mode: _____ TV:_____ 02:_____% PEEP:_____ Rate: _____ Isolation:_____

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Bravo Policy Number: _____ Authorization Number: _____

*Call (1-866) 957-8925 and follow the prompts to set up transports, or check with your Bravo/Cigna Health Spring in-house Representative. *

*******THIS FORM MUST BE COMPLETED IN ITS ENTIRETY!*******

Please make a follow up phone call approximately 20 minutes after faxing to verify we received the request.

Please make sure the patient is ready approximately 90 minutes before appointment time.

Comments: _____

_____