CARES TRIP REQUEST FORM

DISPATCH 740-529-0415

Patient NAME: _____ DOB: ___/__/ _____ DATE: _____

Date of Transport: _____ Diagnosis: _____

Pick-Up locations: _____ Appointment time: _____

Destination: _____ O2: ____

Destination Address: _____

Medical Necessity: _____

Patient weight in pounds: _____

- If possible, please email a factsheet (demographic form) with history and physical, and complete Ambulance form.

Insurance:

Medicare: _____

Medicaid: _____

Part A Facility Pay: _____

Private Insurance: _____

Hospice: _____

*Insurance questions are asked to confirm if we need to obtain prior authorization.

EMAIL COMPLETE FORM TO: dougavery@caresems.com and mattmarcinko@caresems.com you will receive conformation within 24 hours. If this is a late schedule, please call the dispatch number listed above.

Thank you for scheduling with CARES EMS

Trip approved by CARES:

Signature of Person approving: _____