Wellpoint Nonemergency Ambulance Prior Authorization Request

Texas | Medicaid

For **physical health/**medical services, submit completed form by fax to: **866-249-1271**

For **behavioral health/**intellectual and developmental disabilities services, fax to: **844-442-8010**
Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete, and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual (TMPPM)*.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements, or documents; concealment of a material fact; or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm, and agree that by checking "We Agree" that they have read and understand the prior authorization requirements as stated in the relevant Wellpoint provider manual and *TMPPM,* and they agree and consent to the Certification above.

☐We Agree

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

Requesting provider information		
Requesting provider name:*		
Requesting provider NPI:*	Date request submitted:	
Contact name:	Telephone:	Fax:

Rendering provider information		
Rendering ambulance provider:*		Ambulance NPI:*
Tax ID:*	Benefit code:*	Taxonomy:*
Street address:*		
City:	State:	ZIP + 4:*
Contact name:	Telephone:	Fax:

Member information		
Member name (*Last, First, MI*):*		
Member Medicaid number:*	Date of birth:*	
Is the member morbidly obese? ☐ No ☐ Yes	Member weight (*pounds*):	

Are all other means of transport contraindicated? ☐ No ☐ Yes

*If **no**, this member does not qualify for nonemergency ambulance transport.*
*If **yes**, please complete the remainder of the form.*

Reason for transport:	
Origin:	Destination:
Method of transport: ☐ Ground ☐ Fixed wing ☐ Helicopter ☐ Specialized	

Request type

☐ One-time, nonrepeating Date:*

☐ Recurring Number of days requested:*_____days (2 to 60 days) Begin date:*_____

Number of round trips during these authorization dates: _____

Note: *For a recurring request type over 60 days, refer to the Nonemergency Ambulance Exception request in the applicable provider manual and submit this form with the Nonemergency Ambulance Exception Request form.*

Reason for recurring transport (2 to 60 day request type):

☐ Dialysis ☐ Radiation therapy ☐ Physical therapy ☐ Hyperbaric therapy

☐ Other (*explain below*):

Explain why transport is more cost effective than servicing the member at residence:

Requested services	
HCPCS procedure code:*	**Brief description of services:**

Condition affecting transport (check each applicable condition)

Physical or mental condition affecting transport:

Diagnosis code(s):*

Member requires monitoring by trained staff because:

☐ Oxygen (portable O2 does not apply) ☐ Airway ☐ Suction ☐ Hyperbaric therapy

How does the member transfer? ☐ Assisted ☐ Unassisted

Is the member bed-confined (in other words, unable to sit in a chair, stand, and ambulate)? ☐ Yes ☐ No

If **no**, please indicate the following:

Does the member use an assistive walking device? ☐ Yes ☐ No

Is the member able to stand? ☐ Yes ☐ No

The member is able to sit in which of the following for the duration of the transport:

Does the member pose immediate danger to self or others? ☐ Yes ☐ No If **yes**, describe circumstances below:

In addition to ambulance standards, does the member require additional physical restraint? ☐ Yes ☐ No

If **yes**, select the type: ☐ Wrist ☐ Vest ☐ Straps ☐ Other (*describe below*):

☐ Extra attendant must be certified by DSHS to provide emergency medical services (*explain below*):

Condition affecting transport (check each applicable condition)

☐ Continuous IV therapy or enteral/parenteral feedings**
☐ Chemical sedation**
☐ Decreased level of consciousness**
☐ Decreased sitting tolerance time or balance**
☐ Must remain immobile (for example, fracture, etc.)**
☐ Advanced decubitus ulcers**
☐ Contractures limiting mobility**
☐ Wound precautions**
☐ Isolation precautions (VRE, MRSA, etc.)**
☐ Active seizures**

** Provide additional detail (for example, type of seizure or IV therapy, body part affected, supports needed, or time period for the condition) or provide detail of the member's other conditions requiring transport by ambulance:

Certification

I certify that the information supplied in this document is true, accurate, complete, and is supported in the medical record of the patient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and/or state law, which can result in fines or imprisonment in addition to recoupment of funds paid and administrative sanctions authorized by law.

Requesting provider printed name:*

Title: ☐ Physician ☐ Advanced practice RN ☐ Physician assistant ☐ RN ☐ Discharge

Requesting provider NPI:*

Requesting provider signature: Date signed:

Provider Instructions for Nonemergency Ambulance Prior Authorization Request Form

This form must be completed by the provider requesting nonemergency ambulance transportation. Medicaid Reference: Chapter 32.024(t) Texas Human Resources Code

All nonemergency ambulance transportation must be medically necessary. For additional information and changes to this policy and process, refer to the *Texas Medicaid Provider Procedures Manual*:

- **Requesting provider information** — Enter the name of the entity requesting authorization (for example, hospital, nursing facility, dialysis facility, physician).
- **Request date** — Enter the date the form is submitted.
- **Requesting provider identifiers** — Enter the following information for the requesting provider (facility or physician):
  - Enter the requesting provider's name.
  - Enter the National Provider Identifier (NPI) number. An NPI is a 10-digit number issued by the National Plan and Provider Enumeration System (NPPES).
- **Ambulance provider identifier** — Enter the following information for the rendering ambulance provider:
  - Enter the rendering ambulance provider's name.
  - Enter the rendering ambulance provider's NPI.
  - Enter the rendering ambulance provider's Tax ID.
  - Enter the rendering ambulance provider's Benefit Code.
  - Enter the requested ambulance provider's primary national taxonomy code. This is a 10-digit code associated with your provider type and specialty. Taxonomy codes can be obtained from the Washington Publishing Company website at **wpc-edi.com**.
  - Enter the requested ambulance provider's address, including ZIP + 4 code.
- **Member information** — This section must be filled out to indicate the member's name in the proper order (last, first, middle initial). Enter the member's date of birth and member Medicaid number. The member's weight must be listed in pounds. Check yes if the physician has documented that the member is morbidly obese. If a member is currently an inpatient at a hospital facility, any ambulance transports are the responsibility of the hospital. One-time ambulance transports that are related to a hospital discharge may be considered for prior authorization.

- **Requested services** — Enter the requested Healthcare Common Procedure Coding System (HCPCS) procedure code and a brief description of the requested services. The applicable codes are listed below:

Procedure codes			
A0382	A0398	A0422	A0424
A0425	A0426	A0428	A0430
A0431	A0433	A0434	A0435
A0436	A0999		

- **Member's current condition** — This section must be filled out to indicate the member's current condition and not to list all historical diagnoses. Do not submit a list of the member's diagnoses unless the diagnoses are relevant to transport (for example, if member has a diagnosis of hip fracture, the date the fracture was sustained must be included in documentation). It must be clear to Wellpoint when reviewing the request form exactly why the member requires transport by ambulance and cannot be safely transported by any other means.
- **Details for checked boxes** — For questions with check boxes, at least one box must be checked. When sections require a detailed explanation, the information must be provided (for example, if contractures is checked, please give the location and degree of contractures).
- **Isolation precautions** — Vancomycin-Resistant Enterococci (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) are just two examples of isolation precautions. Please indicate in the notes exactly what type of precaution is indicated.
- **Request type** — Check the box for the request type. A one-time, nonrepeating request is for a one-day period. A recurring request is for a period of 2 to 60 days. The provider must indicate the number of days being requested along with the begin date.
- **Name of person signing the request** — All request forms require a signature, date, and title of the person signing the form. A one-time request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner with knowledge of the member's condition. A recurring request must be signed and dated by a physician, PA, NP, or CNS. The signature must be dated not earlier than the 60th day before the date on which the request for authorization is made.
- **Signing provider identifier** — This field is for the NPI number of the requesting facility or provider signing the form.