



# EMS TRANSPORTATION REQUEST

Please Complete Form in its entirety and fax to (850) 921-4100 with all other required forms.

<b>Desired Date:</b>	<b>Time:</b>	<b>Requestor:</b>
<b>Patient Name:</b>		<b>DOB:</b>
<b>To be Transported From:</b> (Facility, Address, Room number, and Phone number)		
<b>To be Transported To:</b> (Facility, Address, Room number, and Phone number)		
<b>Transport Details:</b> (Please include diagnosis and special care required for transport, IV infusions, CPAP, isolation precautions, etc)		
<b>Contact for Transport:</b>		
Name:	Phone:	Fax:
<b>Payment Status: (circle one)</b>		
Health Insurance	Workers Comp	Auto Insurance
Self-Pay	Medicare	Medicaid
Facility to Cover Cost	Agency to Cover Cost	
<b>Responsible Party:</b>		
Address:	City, State, Zip:	Phone#
Insurance Co:	Policy#	Group#
		Approval#
Address:	City, State, Zip:	Phone#
<b>Cost: (Base Transport Cost + mileage)</b> (Call (850) 921-0900 for Quote)	<b>\$</b>	
<input type="checkbox"/> Price Quote Requested <input type="checkbox"/> Physician Certification Statement Faxed to 921-4100 <input type="checkbox"/> Current Demographic/Face sheet Faxed to 921-4100 <input type="checkbox"/> Insurance Information Faxed to 921-4100 <input type="checkbox"/> Bed available at receiving facility - Rm # _____	<b>EMS DISPATCH USE ONLY</b> Time of initial call (requesting quote): _____ Time Completed Paperwork Received: _____ Time facility notified of ETA: _____ Time Ambulance arrived for pick-up: _____ Time Ambulance departed for trip: _____ Delays: _____	
<b>Requesting Staff Signature</b> X _____		
<b>Print Name &amp; Title:</b>		