Non-Emergency Ambulance Transportation Prior Authorization Request

Request Type: ___Initial ___Resubmission ___Expedite, reason:______________________________________

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Patient Information:

Last name: ______________________________ First name: ______________________________ MI: ____

DOB (MM/DD/YYYY):__________________ Gender: __ M __ F __ Other Medicare ID:__________________

Certifying physician / practitioner information:

Last name:____________________________ First name:______________________ MI:___ Suffix:____

NPI:__________________________ Place of employment:____________________________________

Address:____

City:____________________________________ State:______ Zip:______________

PTAN:________________________ Telephone number and extension: (____) ____-_____ x _______

Direct address:____

Ambulance supplier information:

Name: Coastal Ferry LLC NPI: 1912592031

Address: 1948 Charla Lee Ln.

City: Virginia Beach State: VA Zip: 23455

PTAN:__________________________ Fax number and extension: (757) 663-7600 x _______

State where ambulance is garaged: VA

Start date (MM/DD/YYYY):__________________ End date:_______________ Round trip: ___ Yes ___ No

Transport from ____ Home, or ___________________________ To:____________________________

Number of transports requested in a 60-day period:______

Procedure Code:______________________ *Modifier 1:*_______________ *Modifier 2:*_____________

Requestor: Telephone number and extension: (____)____-_______ x ________

Last name:________________________________ First name:_________________________ MI:_____

Fax number and extension: (____)_____-_________ x _________

Direct address:____

Submission date (MM/DD/YYYY):____________________

For accurate insurance claims please fill out form in it's entirety, missing information on this form can lead to a denial of claims on Medicare's behalf.