PROVIDENCE TRANSPORTATION

STRETCHER REQUEST

Phone: 336-472-7433 Fax: 336-477-2101
Email: ambdispatch@providencetransport.com
ALL INFORMATION MUST BE FILLED OUT BEFORE FAXING

APPT DATE: _____ **P/U Time:** _____ **APPT Time:**_____**(note if multiple times)**

Appointment Type: Regular/Follow Up, Procedure, Surgery, Discharge, Non-Medical

Expected Length of Appt: _____ **Trip Type:** Round trip One Way 911

Facility Pick-Up: _____ **If Residence:** Ramp or # Steps: _____

Address of Pick-Up: _____**Apt or Suite#**_____

Patient's Name: _____ **M/F**_____

Patient's Date of Birth:_____ **Patient's Room#:**_____ **Patient's Wt:** _____**Ht:**_____

Reason for Stretcher? ***Must have medical necessity/PCR form filled out with justifiable reason for Medicaid or Medicare transport.***

_____

***There will be a Wait Time charge in addition to the Trip Fee if patient stays on stretcher for their appointment.**

Circle if any Apply: O2_____ Contact Precaution Amputee Blind Mentally Impaired Combative PICC PRN Adaptor/IV Trach Humidifier Other:_____

Name of Person Placing Order & Phone Number:_____

Destination Information:

Name of Facility: _____**If Residence:** #of Steps: _____

Address of Facility:_____

Phone Number of Facility: _____ **Apt orSuite#**_____

Is patient being discharged to Hospice Care? Y/N
If yes, Is this the initial Hospice Admission? Y/N

How is this being paid? Circle one:
Patient Facility ATM-VA

Medicare Medicaid Other INS

Hospice Agency:_____

SS#_____
Medicare#_____
Medicaid#_____
Other Insurance#_____

IF PATIENT IS SELF PAY:
CC#_____ **Quote Amount:**_____

EXP:_____CVV:_____ZIP:_____

Email, fax or address for receipt:_____

Notes/Special Instructions: _____

Call Taken by: _____**Insurance Checked by:**_____