AmeriKare AMBULANCE

PLEASE USE THIS FORM TO SCHEDULE MULTIPLE APPOINTMENTS

(ONE PATIENT ONLY PLEASE)

AMERIKARE AMBULANCE – (614) 626-0466

FAX- (614-626-0910)

Name: **DOB:** **Gender:**

Primary Insurance & Id Number:

Private Pay Contact Information:

Name: **Phone:**

Patients Weight

Type of Transport: [_____] Stretcher [_____] Wheelchair [_____] Patients Wheelchair

Medical Necessity/Special Needs

SKILLED NURSING FACILITY PAYMENT AGREEMENT SECTION

AMERIKARE LLC. AND SKILLED NURSING FACILITY

BUSINESS NAME:

ARE IN AGREEMENT TO THE FOLLIOWING WITH REAGARDS TO:
TO PROVIDE PAYMENT FOR SERVICES RENDERED BY PROVI MEDICAL TRANSPORTATION
ON THE BEHALF OF THE PATIENT IE: AMBULANCE AN/OR AMBULETTE

ADMINISTRATOR/AUTHORIZED PERSONNEL (PRINT NAME)

ADMINISTRATOR/AUTHORIZED PERSONNEL (SIGNATURE)

Please fax reservation request to AmeriKare Ambulance at 614-626-0910. Thank you!

7 DAY TRANSPORT REQUEST SCHEDULE 2016-2017

1 **DATE:**
TIME:
Pick Up Location:
Drop Off Location

2 **DATE:**
TIME:
Pick Up Location:
Drop Off Location

3 **DATE:**
TIME:
Pick Up Location:
Drop Off Location

4 **DATE:**
TIME:
Pick Up Location:
Drop Off Location

5 **DATE:**
TIME:
Pick Up Location:
Drop Off Location

6 **DATE:**
TIME:
Pick Up Location:
Drop Off Location

7 **DATE:**
TIME:
Pick Up Location:
Drop Off Location