Phone: 614.626.0466
Fax: 614.626.0910

NON-EMERGENT
Patient Transportation Request Form

please write legibly

Patient Name: ______________________________DOB: ____________________ Gender: ____
Weight: __________________ lbs/kls Social Security Number: _______________________
Primary Insurance: ___________________________ Insurance Number: ____________________
Secondary Insurance: _________________________ Insurance Number: ____________________

Please provide face sheet for patient

Private Pay Contact Information: ____
____

Transport Date: _______________________ Appointment Time: _________________________

Reason for Transport: ____
Type of Transport: [___] Stretcher [___] Wheelchair [___] Patients Wheelchair

we cannot accommodate wheelchairs over 32" wide; most power wheelchairs are not suitable for transport.

Special Needs: ____

Pick Up Location: ____ Room #: __________
Address: ____
City: _______________________________________ State: ____________ Zip: ______________
Pick up location additional notes:____
Drop Off Location: ____ Room #: __________
Address: ____
City: _______________________________________ State: ____________ Zip: ______________
Drop Off location additional notes:____
Doctor Name: ________________________ Phone number: ____________________________
Requested by: _______________________ Requestor phone number: ___________________

Prior authorization is required from AmeriKare Management for all wait and return trips.

Please fax reservation request to AmeriKare Ambulance at 614.626.0910. Thank you!

Updated 8/13/2018