Hart to Heart TRANSPORTATION
The vital link in community health care

Phone (866) 276-9554
Fax (877) 483-3608

Comm Center Rep: _____

EVS: _____ Auth: _____

Intake Date: _____

H2H Intraoffice Use Only - Do Not Complete

Transportation Request

Person Requesting Transport:	**Phone #**:	**Ext**:
Requesting Facility:	**Bill Facility Approval**: ☐ Yes ☐ No	
Patient Name:	**Treating Physician NPI #**:	
Date of Transport:	**Pickup Time**:	**Appointment Time**:
Weight:	**Height**:	**Room #**:

Type of Transport:

☐ AMBULANCE ☐ BARIATRIC AMB ☐ BLS ☐ ALS (Paramedic only) ☐ SCT/CCT/NEONATE

☐ WHEELCHAIR ☐ BARIATRIC W/C ☐ AMBULATORY ☐ ELECTRIC SCOOTER

Req. Escort: ☐ Yes ☑ No **DNR**: ☐ Yes ☐ No **Oxygen**: ☐ Yes ☐ No LPM: _____

Destination Facility:	
Street Address:	**Zip Code**:
Physician's Name:	**Phone #**:

Reason for Transport:

☐ DISCHARGE TO HOME ☐ DISCHARGE TO FACILITY ☐ PSYCH TRANSFER ☐ MEDICAL TRANSFER

☐ DOCTOR APPT ☐ RADIATION/CHEMO ☐ PROCEDURE

☐ WOUND CARE ☐ IMAGING ☐ OTHER

☐ DIALYSIS ☐ S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S **Times:** _____

Billing:

☐ MEDICAID MDMA # _____

☐ MEDICARE Medicare # _____

☐ OTHER INSURANCE Type and # _____

Responsible Party:	**Relationship**:
Address:	**Phone #**:

FAX FACE SHEET WITH REQUEST
PLEASE SEND PCS FOR STRETCHER REQUESTS
Reminder: PCS for dialysis transports requires MD signature