**Prior Authorization**

Patient full legal name:_____

Patient date of birth:_____

Insurance group number:_____

Insurance or Medicare ID number:_____

Certifying Physician's name:_____

Certifying physician's NPI:_____

Certifying Physician's PTAN:_____

Certifying Physician's address:_____

_____

_____

Number of transports being requested (1 round trip = 2 transports)_____

_____

**In addition to this information, a medical necessity form must be completed and signed by a **PHYSICIAN** only **AND** supporting documentation showing why transport by other means is contraindicated.