NC DHB Request for Prior Approval

STATE TO STATE AMBULANCE TRANSPORTATION ADDENDUM

Recipient Information **DMA372-118A v1.0**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Provider Information

6. Rendering Provider # (if different from billing):_____NPI: ☐ Atypical: ☐ 7. Taxonomy: _____
8. Address: _____ 9. Nine Digit Zip Code: _____
Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Service Information

10. Facility (Point of Pickup): _____
11. Facility (Destination): _____
12. Date of Service _____

Additional Information

(Include any additional information related to this request)

Please attach letter (signed by attending physician), which includes

- Medical diagnosis
- Recipient's physical condition
- Ambulance transportation justification

I verify that there are no resources other than Medicaid to pay for the transportation:

_____ _____
Signature/Title **Date**

County _____
Telephone Number _____
Contact Person _____

Fax this form to: (855) 710-1964