To: Transportation Providers
From: IEHP – Provider Relations
Date: March 11, 2021
Subject: **Transportation Requests for Acute Hospitals**

Effective immediately, Inland Empire Health Plan (IEHP) will require that all Acute Hospitals utilize the revised Transportation Request Form (Hospital) when scheduling transportation for IEHP Members. **The attached form has been updated to include the Member's COVID-19 status for transportation** and is also available on the Non-Secure website at:

www.iehp.org > Providers > Provider Resources > Forms > UM/CM > Transportation Requests Form (Hospital) (PDF)

A Physician Certification Statement (PCS) is required for all Non-Emergent Medical Transportation (NEMT) requests. If Member does not have a valid PCS on file, the facility must submit PCS with transportation request.

Please note, DHCS requires a **new PCS every twelve (12) months**. Link to PCS training guide: https://ewebapp.iehp.org/ProviderPortal/Content/pdfs/20171127-PCS_NEMT_Services_Request_Instructions.pdf

Transportation requests which do not include both the Transportation Request Form and the PCS (when applicable) may be subject to denial.

When possible, facilities should provide **five (5) business days** advance notice to allow for the processing of the request. Once the transportation trip has been authorized, the facility will receive an authorization notification via fax and/or the facility can check the status on the secure IEHP Provider Portal.

This process will apply to all IEHP Members, regardless of IPA or Line of Business.

As a reminder, all communications sent by IEHP can also be found on our Provider portal at: www.iehp.org > For Providers > Plan Updates > Correspondences

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

Enclosure: Transportation Request Form (Hospital)

INLAND EMPIRE HEALTH PLAN

*Required Field

TRANSPORTATION REQUEST FORM (HOSPITAL)

Today's Date: _____ **Discharge Date/Time:** _____

Member Name: _____

IEHP Member ID: _____ *** Height:** _____ *** Weight:** _____

Trach to Ventilator: ☐ Yes ☐ No **Suctioning:** ☐ Deep ☐ Mild ☐ Shallow

Oxygen: ☐ Yes ☐ No Liter Flow: _____ Comments: _____

** Height and weight only required if Member is transported via wheelchair or gurney.*

COVID-19 TEST DATA

Test Administered: ☐ Yes ☐ No ☐ Unknown **Test Date:** _____ **Result Date:** _____

Test Results: ☐ COVID-19 Positive ☐ COVID-19 Negative ☐ Unknown

TRANSPORTATION FROM

Facility & Treating Physician: _____ **Room#:** _____

Address: _____

City: _____ **ZIP:** _____

Contact Person: **Phone:**

TRANSPORTATION TO HOME

Facility (if applicable):

Receiving Dr./Caregiver _____ **Room#:** _____

Address: _____ **Phone:**

City: **ZIP:**

FOLLOW UP APPOINTMENTS

☐ Dialysis ☐ Chemotherapy/Radiation ☐ Other: _____

Appointment Date: _____ Dialysis Days: _____

Appointment Time: Start Date: Chair Times:

TRANSPORTATION BY

☐ Ambulatory

☐ Wheelchair ☐ Vendor to provide wheelchair (NOTE: Gurney will be provided when no W/C availability)

☐ Bariatric ☐ Standard Wheelchair ☐ Wide Wheelchair ☐ Electric Wheelchair

☐ Gurney ☐ ALS ☐ BLS ☐ CCT (only) ☐ Bariatric

☐ Attendant/Caregiver Sending Dr.

Receiving Dr./Caregiver

Please fax request to **IEHP UM Transportation Department (909) 912-1049**

P.O BOX 1800 Rancho Cucamonga CA 91729-1800
Phone: (951) 374-3441 Fax: (909) 912-1049
Visit our web site at: www.iehp.org
A Public Entity

Revised: 08/17/2020