



To: Skilled Nursing Facilities & Long-Term Care Facilities
From: IEHP – Provider Relations
Date: March 11, 2021
Subject: **Transportation Requests for SNFs and LTCs**

Effective immediately, Inland Empire Health Plan (IEHP) will require that all Skilled Nursing Facilities and Long-Term Care Facilities utilize the revised Transportation Request Form (SNF & LTC) 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 (SNF<C) (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 (SNF & LTC)



INLAND EMPIRE HEALTH PLAN

***Required Field** **TRANSPORTATION REQUEST FORM (SNF & LTC)**

Today's Date: _____

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/Facility: _____ **Room#:** _____

Address: _____ **Phone:** _____

City: _____ **ZIP:** _____

APPOINTMENTS: (Please send request within five (5) Business Days of appointment date)

Dialysis **Chemotherapy/Radiation** **Other:** _____

Appointment Date: _____ **Dialysis Days:** _____

Appointment Time: _____ **Start Date:** _____ **Chair Times:** _____

TRANSPORTATION BY ①

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**

Attendance/Caregiver **Sending Dr** **Receiving Dr/Caregiver**

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

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 Visit our web site at: www.iehp.org
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