INLAND EMPIRE HEALTH PLAN

Transportation Request Form (Hospital)

TODAYS DATE: _____ *** Discharge Date/Time:** _____

*** NAME:** _____

*** IEHP ID#:** _____ **Height:** _____ **Weight:** _____

(Height & Weight needed only if Member is going by Wheelchair/ Gurney)

SPECIAL NEEDS: ☐ Trach to Ventilator; **Suctioning**: ☐ Deep ☐ Mild ☐ Shallow

Oxygen: ☐ Yes ☐ No Liter Flow: _____ **Comments** *(if any)*: _____

* TRANSPORTATION FROM:

Facility: _____ Room #: _____

Address: _____

City: _____ Zip: _____

Contact Person: _____ Phone #: _____

* TRANSPORTATION TO HOME:

Facility (if applicable): _____ Room #: _____

Address: _____ Phone #: _____

City: _____ *Zip: _____

FOLLOW UP APPOINTMENTS:

☐ Dialysis ☐ Chemo/Radiation ☐ Other: _____

Appointment Date: _____ Dialysis Days: _____

Appointment Time: _____ Start Date: _____

Chair Times: _____

* TRANSPORT BY:

☐ AMBULATORY

☐ WHEELCHAIR: ☐ Vendor to provide wheelchair

☐ Bariatric ☐ Standard Wheelchair ☐ Wide Wheelchair ☐ Electric Wheelchair

☐ GURNEY:

☐ ALS ☐ BLS ☐ CCT ☐ Bariatric

☐ ATTENDANT/CAREGIVER

*** Denotes Required Field**

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: 04/07/2017