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**

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

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