PRESTIGE
PATIENT TRANSPORT LLC

CONFIRMATION INFORMATION

Scheduled Pickup Time_____

Miles _____ Duration _____

SCHEDULED MEDICAL TRANSPORTATION FORM

A fee of $210.00 will be billed to the pickup facility for any scheduled transport where we arrive and the patient is no longer at the facility or other transport was arranged and we were not notified.

Pick Up Date _____/_____/ 20____ Day of Week _____

Scheduled Appointment Time_____ Estimated Time of Visit (how long?)_____

Transport Requestor Name_____ Number_____

Patient Name _____ DOB_____

InsuranceCompany_____

Pick Up Location _____

Destination (Full Address Including Zip) _____

Destination Room Number _____ Patient's Facility Floor/Room No_____

Reason for Transport /Type of Appointment _____

IV Pump Needed? ☐ Yes ☐ No Fluids Running _____

Cardiac Monitor Needed? ☐ Yes ☐ No Patient Weight (no bariatric) _____

Oxygen Required? ☐ Yes ☐ No Patient Height _____

Infectious Precautions or Special Care_____

_____

_____

☐ Check box if patient is skilled.

☐ Check box if facility is NOT responsible for final payment after insurance payment. If other:

Responsible Party _____ Phone _____

Address _____

IF YOU DO NOT RECEIVE CONFIRMATION OF THIS REQUEST WITHIN 24 HOURS OR FOR AFTER HOURS REQUEST, PLEASE CALL OUR OFFICE TO CONFIRM.

Dispatch: 937-690-6100 Email: info@prestigepatienttransport.com Fax: 888-273-7025