PRESTIGE
PATIENT TRANSPORT LLC
AMBULANCE

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 ___________________________

Insurance ______________________________________ SS # ____________________________

Pick up location ____

____ Room/Bed No __________________

Destination (full address including zip) ____

____ Facility Room No _______________

Physician's Name _____________________________ Office Phone No ____________________

Chief Complaint/Type of Appointment ____

IV pump needed? ☐ Yes ☐ No Fluids running ____

Cardiac Monitor needed? ☐ Yes ☐ No

Oxygen required? ☐ Yes ☐ No

Patient weight (call if over 350 lb) ____________

Patient height ____________________________

Patient Sex ☐ Male ☐ Female ☐ Other

Infectious precautions or special care ____

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☐ 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