

Non-Emergency Medically Necessary Ground Transportation



Coverage guidelines for Commercial members:
AllWays Health Partners covers **non-emergency medically necessary** transportation services to the nearest location capable of providing the medically necessary care required by the member.

Note: coverage does not apply to My Care Family (MassHealth).

Documentation: For all non-emergency ground transportation services to be covered, they must be medically necessary and reasonable. Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Refer to the **Non-Emergency Medically Necessary Transportation Policy**.

To support efficient claims processing, AllWays Health Partners requires services to be provided by contracted (participating) ambulance providers. A list of contracted ambulance providers is available at **allwayshealthpartners.org**.

All fields marked with an asterisk are required.

A. Member information		
1. Member name*	2. Member ID* (include all numbers and letters)	3. Date of birth*
4. Address Street _____ City _____ State _____ Zip _____		
5. Cell phone number*	6. Home phone number	7. E-mail address
8. Primary language	9. Subscriber name, if different from member	

B. Requested Service and Trip Information*	
10. Transportation service requested <input type="checkbox"/> Chair car <input type="checkbox"/> Non-emergency ground ambulance	11. Number of trips requested
12. Dates of service Start date _____ End date _____	
13. Medical service provided to member at destination	
14. Pick up location, choose one <input type="checkbox"/> Address listed above	
<input type="checkbox"/> Health care facility _____ Street _____ City _____ State _____ Zip _____	
<input type="checkbox"/> Other _____ Street _____ City _____ State _____ Zip _____	
15. Destination location Provider _____ Phone _____ Street _____ City _____ State _____ Zip _____	
16. Ambulance/Chair Car Servicing Provider Provider _____ Phone _____ Provider contact _____ Email _____	

continued

C. Required Signatures

Primary Care Clinician (Physician/Nurse Practitioner)*

Signature _____ Date _____

Title _____ Phone _____ Email _____

If there is no primary care clinician or nurse practitioner, the AllWays Health Partners Clinical Care Manager must sign this form.

AllWays Health Partners Clinical Care Manager*

Signature _____ Date _____

Title _____ Phone _____ Email _____

This completed form should be submitted to the ambulance provider for non-emergency ground transportation.