Non-Emergency Medically Necessary Ground Transportation

Mass General Brigham Health Plan

Coverage guidelines for Commercial members: Mass General Brigham Health Plan 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 MassHealth members.
All fields marked with an asterisk are required.

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, Mass General Brigham Health Plan requires services to be provided by contracted (participating) ambulance providers. A list of contracted ambulance providers is available at **massgeneralbrighamhealthplan.org**.

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

☐ Chair car ☐ 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*

☐ Address listed above

☐ Health care facility _____

Street _____ City _____ State _____ Zip _____

☐ 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 Mass General Brigham Health Plan Clinical Care Manager must sign this form.

Mass General Brigham Health Plan Clinical Care Manager*

Signature _____ Date _____

Title _____ Phone _____ Email _____

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