

Appendix IX — Healthfirst Transportation

Appendix IX-A — Provider Approval Form

Instruction: This form should be completed and signed by the provider responsible for the physical or behavioral health of the Healthfirst member indicated below. If the member requires medically necessary, non-emergency taxi, ambulette, or ambulance transportation to and from medical services, please fax a completed form to Member Services at **1-212-801-3250**.

Date: _____
Member Name: _____ CIN Number _____
Required Mode of Transportation: Taxi/Livery Ambulette Ambulance
Other: _____
Extent for Requirement: No. Trips: _____ -and- From: _____ Thru: _____
MM/DD/YY MM/DD/YY

Medical Justification (please indicate diagnosis and why it prevents member from using public transportation):

Other Assistance Required: Wheelchair Stretcher Other _____

Comments: _____

Provider Signature Phone Number Date

Provider Name (please print) Healthfirst ID # Hospital Affiliation

COMPLETED FORMS: Healthfirst Member Services Transportation
P.O. Box 5165
New York, NY 10274
Fax: **1-212-801-3250**
Phone: **1-866-463-6743**