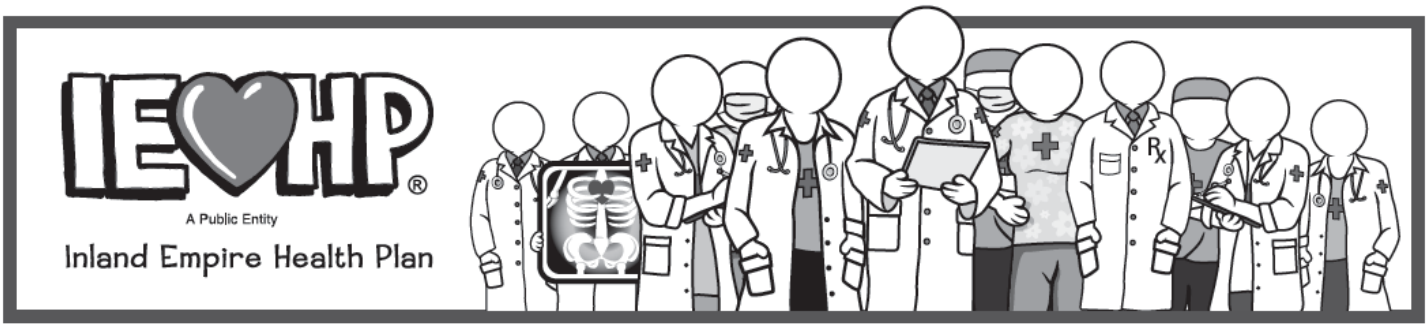


**To:** Hospital Administrators

**From:** IEHP – Provider Relations

**Date:** July 17, 2017

**Subject:** **REMINDER: Transportation Request (Hospital)**

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**Effective July 10, 2017**, Inland Empire Health Plan (IEHP) will require that all Acute Hospitals utilize the attached Transportation Request Form (Hospital) when requesting transportation for IEHP Members upon discharge.

The Transportation Request Form (Hospital) will allow IEHP to identify the suitable level of transportation for each Member and provide the appropriate authorization prior to discharge. Requests for Member transport from an Acute Hospital to home must be submitted to IEHP in advance of the Member's discharge so it will not delay the discharge process. This process will apply to all IEHP Medi-Cal and DualChoice Cal MediConnect Members, regardless of IPA. For your convenience, an electronic copy of the Transportation Form (Hospital) is available on our Provider Portal at the following address: https://ww3.iehp.org/en/providers/forms/um-forms/.

As a reminder, all communications sent by IEHP can also be found on our Provider portal at the following address: https://ww3.iehp.org/en/providers/correspondence/.

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

**Enclosure:** Transportation Request Form (Hospital)

INLAND EMPIRE HEALTH PLAN

# Transportation Request Form (Hospital)

**TODAYS DATE:** _____ *** Discharge Date/Time:** _____

*** NAME:** _____

*** IEHP ID#:** _____ **Height:** _____ **Weight:** _____

*(Height & Weight needed only if Member is going by Wheelchair/ Gurney)*

**SPECIAL NEEDS:** ☐ Trach to Ventilator; **Suctioning**: ☐ Deep ☐ Mild ☐ Shallow

Oxygen: ☐ Yes ☐ No Liter Flow: _____ **Comments** *(if any)*: _____

## * TRANSPORTATION FROM:

Facility: _____ Room #: _____

Address: _____

City: _____ Zip: _____

Contact Person: _____ Phone #: _____

## * TRANSPORTATION TO HOME:

Facility (if applicable): _____ Room #: _____

Address: _____ Phone #: _____

City: _____ *Zip: _____

## FOLLOW UP APPOINTMENTS:

☐ Dialysis ☐ Chemo/Radiation ☐ Other: _____

Appointment Date: _____ Dialysis Days: _____

Appointment Time: _____ Start Date: _____

Chair Times: _____

## * TRANSPORT BY:

☐ AMBULATORY

☐ WHEELCHAIR: ☐ Vendor to provide wheelchair

☐ Bariatric ☐ Standard Wheelchair ☐ Wide Wheelchair ☐ Electric Wheelchair

☐ GURNEY:

☐ ALS ☐ BLS ☐ CCT ☐ Bariatric

☐ ATTENDANT/CAREGIVER

*** Denotes Required Field**

Please fax request to **IEHP UM Transportation Department (909) 912-1049**

P.O BOX 1800 Rancho Cucamonga CA 91729-1800
Phone: (951) 374-3441 Fax: (909) 912-1049
Visit our web site at: www.iehp.org
A Public Entity

Revised: 04/07/2017