ROLLING HILLS CLINIC

Non-Emergency Transportation Application Form

1 PATIENT INFORMATION

Last Name ______ First Name ______ MI ______ Date of Birth ______

Street Address ______ City, State, Zip ______

Email Address ______ Home Phone ______ Cell Phone ______

2 TRIBAL MEMBERSHIP

Tribe of Membership ______ Roll Number ______ Certificate of Indian Blood (CIB) ______ State Enrolled ______

3 MEDICAL INSURANCE INFORMATION - Please check with your insurance to arrange for transportation before submitting form.

Primary Insurance

Subscriber Name ______ Subscriber ID# ______

Insurance Company ______ Insurance Phone # ______

Secondary Insurance

Subscriber Name ______ Subscriber ID# ______

Insurance Company ______ Insurance Phone # ______

4 MODE OF TRANSPORTATION INFORMATION

1. Does the patient have any other mode of transportation available to them?
 ____Yes ____No

2. Is the requested mode of transportation a long term need or temporary:
 ____Long Term ____Temporary How many months? ____

3. Is the patient able to travel alone? ____Yes ____No

If no, please state reason: ______

APPLICATION CONTINUED ON PAGE 2 ->

For RHC Transportation Department Use ONLY:

Date Received: ______

Application Approved: ____

Date Approved: ______

Type of Transportation Required: ____Car/Van ____Wheel Chair Accessible

Application Denied: ____ Reason: ______

Authorized Transportation Staff Signature: ______

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Patient Name:

5 MEDICAL NECESSITY

1. Please check the medical necessity for transportation services:

_____ Livery: The enrollee can walk to the curb and board and exit the vehicle unassisted, but has no other means of transportation available.

_____ Ambulette Ambulatory: The enrollee can walk but requires driver assistance from residence to the medical appointment.

_____ Ambulette Wheelchair: The enrollee is a wheelchair user, requires a lift-equipped or roll up wheelchair vehicle and driver assistance.

2. Please justify the mode of transportation chosen above:

_____ Use of portable oxygen or other necessary equipment that the patient is unable to carry.

_____ Limited use, or no use, of one or both legs (i.e. broken leg)

_____ Inability to walk 50-60 feet without stopping

_____ Other limitations ______________________________

6 Certification Statement

I certify under penalty of perjury that everything in this application is true and that anyone who knowingly lies or hides the truth in order to receive services under this program is committing a crime and subject to federal penalties. I also understand that my patient chart records may be audited to verify the above information.

Patient Signature: ______________________________ Date: ______________

Attending Provider Name: ______________________________ Date: ______________

Please complete all sections, print and sign and date form. You may turn in to front desk or send by email to
Thank you.

Please note: *RHC Transportation Services are available for patients who do not have access to other forms of transportation. Most insurance companies do provide transportation services. If you have insurance but are ineligible for or unable to use their services, please attach documentation to that effect.*