INLAND EMPIRE HEALTH PLAN

TRANSPORTATION REQUEST FORM (SNF & LTC)

IEHP Member ID:			**DC Date and Time:**			
Member Name:			***Height:**		***Weight:**	
Trach to Ventilator:	☐ Yes	☐ No	**Suctioning:**	☐ Deep	☐ Mild	☐ Shallow
Trach to Oxygen:	☐ Yes	☐ No	**Liter Flow:**		**FIO2:**	
Trach to Room Air:	☐ Yes	☐ No				
Oxygen:	☐ Yes	☐ No	**Comments:**			

**Height and weight are required if Member is transported via wheelchair or gurney.*

COVID-19 TEST DATA

Test Administered:	☐ Yes	☐ No	☐ Unknown	**Test Date:**	
Test Results:	☐ COVID-19 Positive	☐ COVID-19 Negative	☐ Unknown	**Result Date:**	

TRANSPORTATION FROM

Facility & Treating Physician:	**Room #:**
Address:	
City:	**Zip Code:**
Contact Person:	**Phone:**

TRANSPORTATION TO HOME

Facility (if applicable)	**Room #**
Receiving Dr./Facility:	**Phone:**
Address:	
City:	**Zip Code:**

APPOINTMENTS: (Please send request within five (5) business days of appointment date)

	Dialysis	Chemotherapy	Radiation	Other:	
Appointment Date:			Dialysis Days:		
Appointment Time:			Start Date:		Chair Times:
Approximate Wait Time:			Wait & Return:	☐ Yes	☐ No

TRANSPORTATION BY:

☐ Ambulatory					
☐ Wheelchair:	☐ Standard	☐ Bariatric	☐ Wide	☐ Electric	☐ Vendor to provide w/c
☐ Gurney:	☐ ALS	☐ BLS	☐ CTT (Only)	☐ Bariatric	
Attendance/Caregiver	☐		Note:	Gurney will be provided when no w/c availability	
Sending Dr.			**Receiving Dr/Caregiver**		

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: (951) 912-1049
Visit our website at: www.iehp.org
A Public Entity

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