COLORADO
Department of Health Care Policy & Financing

NEMT Air, Train, and Out-of-State Request Form
(NEMT Request Form)

Date of Request:_____ Requestor's Name:_____

Complete this form thoroughly to request prior approval of air, train, and out-of-state Medicaid Non-Emergent Medical Transportation (NEMT).

- Health Care Policy & Financing (HCPF) prior approval is required for all air, train, and out-of-state NEMT.
- All out of state requests must include a Colorado physician's attestation and documentation that the service cannot be performed in Colorado. We strongly recommend this request be prepared by medical professionals.
- After completion, submit the form and supporting documentation via email or fax.

Email: NEMT@state.co.us
Fax: (303) 866-2573 (Attention: NEMT)
** All incomplete forms will be returned to the sender*

Prior Authorization Request (PAR)

NEMT can only be used to access approved medical services.
10 CCR 2505-10 8.013 Requires all medical services to be provided in Colorado, unless the service is not available in-state.

Below is the Health First Colorado PAR process:

Out of State **Inpatient** Services: A Prior Authorization Request (PAR) for an out of state, inpatient stay must be submitted to eQHealth, the Department's third party Utilization Management contractor, by the client's medical provider before an NEMT request can be approved. The approved PA number and clinical information supporting the request must be submitted with the NEMT request. A PAR is not required for the inpatient stay if the member has private insurance other than Health First Colorado. Please submit the primary insurance approval form with your NEMT request.

- HCPF prior approval is required for all air, train, and out-of-state NEMT.

Out of State **Outpatient** Services: eQHealth does not issue PAs for outpatient visits, unless the actual procedures require a PAR. HCPF's Chief Medical Officer, or designee, will review the NEMT travel requests requiring air, train, and out-of-state travel. All requests must include clinical information supporting the request, including the PA number if the procedure requires a PAR.

- HCPF prior approval is required for all air, train, and out-of-state NEMT.

In-State Air & Train Transportation: HCPF's Chief Medical Officer, or designee, will review the NEMT travel requests for air or train for all in-state travel. All requests must include clinical information supporting the request.

- HCPF prior approval is required for all air, train, and out-of-state NEMT.

eQHealth can be reached at:
888-801-9355 or www.coloradopar.com

Treatment Requires a PAR? ☐Yes ☐No PAR Obtained By:_____ PA #:_____ PA Approval Date:_____

Member Information

Member's Name:_____
Last First M.I.

Date of Birth:_____ State ID Number:_____

Does the Member have Private Insurance? ☐Yes ☐No

Is this member being referred to an Indian Health Services provider? ☐Yes ☐No

Private Insurance Name:_____

Has Private Insurance Approved This Treatment? ☐Yes ☐No ☐N/A **If yes, a copy of the private insurance approval must be submitted with this request.**

Private Insurance Approver's Contact Information:_____

Travel Information

Traveling From:_____ Traveling To:_____

Date of Travel: ____ Length of Stay: _____

Meals Requested? ☐Yes ☐No | Lodging Requested? ☐Yes ☐No | Escort Required? ☐Yes ☐No | Type(s) of transportation requested: _____

Treatment Information

Is treatment available in Colorado? ☐Yes ☐No

Where will the care be delivered? ☐Inpatient ☐Outpatient

Referring Colorado Provider Name and NPI: _____

Referring Provider Contact Information: _____

Accepting Provider Name and NPI: _____

Accepting Provider Contact Information: _____

Provide a brief case synopsis below. The care plan and any required clinical documentation, including why the procedure cannot be performed in Colorado (if out of state request) ***must*** be submitted as an attachment with this form.

HCPF Use Only

ESPDT Decision: _____ ☐Approve ☐N/A ☐Deny _____

Name | Date

Medical Director, or designee, Decision: _____ ☐Approve ☐N/A ☐Deny _____

Name | Date

Denial Reason (if applicable):

Date Sent Decision to County or Veyo: _____ Sent By: _____