



Date of Request: Date Requestor's Name: Name

Complete this form thoroughly to request prior approval of air, train, and out-of-state Medicaid Non-Emergent Medical Transportation (NEMT). HCPF prior approval is required for all air, train, and out-of-state NEMT. We strongly recommend most of this request be prepared by medical professionals because a physician will be reviewing the request. After completing this form, submit the form and supporting documentation via email or fax. All incomplete forms will be returned to the sender.

**Email: NEMT@state.co.us
Fax: (303) 866-2573 (Attention: NEMT)**

Inpatient care: Before an NEMT request can be submitted, the actual medical services must receive the appropriate PAR from eQHealth. Include the approved PAR and detailed case information with your NEMT Request to help expedite the process.

eQHealth can be reached at:

<http://co.eqhs.org/> 888-801-9355 (toll free phone)

Additionally, a statement that a bed is available is required for inpatient care.

Outpatient Services: eQHealth does not issue PARs for outpatient services. Medicaid's Medical Director will review the NEMT travel requests requiring air, train, and out-of-state travel.

Member Information

Child's Name (for EPSDT)/ Member's Name: Last First MI
Last First M.I.
Date of Birth: DOB State ID Number: ID Number

Travel Information

Traveling From: Enter Where Traveling From Traveling To: Enter Receiving Facility & Doctor Name
Date of Travel: Date of Travel Length of Stay: Length of Stay
Meals Requested? Lodging Requested? Escort Required? Type(s) of transportation requested:
Yes No Yes No Yes No e.g., air ambulance, mileage reimbursement, etc.

Treatment Information

Treatment Available in Colorado? Does the Member have Private Insurance? Has Private Insurance Approved This Treatment? Is The Treatment Inpatient or Outpatient?
Yes No Yes No Yes No N/A Inpatient Outpatient

Treatment Plan: *(expandable)*

Click here to enter Treatment Plan. Attach additional documentation, if necessary.

What has already been tried that led to this point? Enter Response
What are the expected outcomes? Enter Response
How was it determined this is not offered in Colorado? Enter Response
Why is this surgery needed? Enter Response

Prior Authorization Request (PAR)

Treatment Requires a PAR? PAR Obtained By: PAR #: PAR Length:
**Required for inpatient care* Yes No Enter Name Enter PAR Number Enter Length

HCPF Use Only

ESPD T Approval: EPSDT Approver Name Approve N/A Deny Approval Date
Chief Medical Officer Approval: Chief Medical Officer Approver Name Approve N/A Deny Approval Date

Date Sent Decision to County or Total Transit: Enter Date Sent By: Enter Name of HCPF Sender