

ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program/Newborn Intensive Care Program
Request for Maternal Transport

PATIENT'S INFORMATION

1. Last Name		2. First Name		3. MI	4. SS#
5. Alias: Last Name		6. Alias: First Name		7. Maiden Name	
8. Street Address		9. City	10. State	11. Zip	12. County
13. DOB	14. Preferred Language		15. Marital Status	16. Phone # ()	
17. Race		18. Ethnicity		19. Tribe	20. Reservation

CONTACT INFORMATION

21. Contact: Last Name		22. First Name	23. Relationship
24. Phone # ()	25. Phone Type	26. Comments	

TRANSPORT INFORMATION

27. Authorizing Physician: (Program Perinatologist)		28. Transport Date:	
29. From Facility:		30. To Facility:	
31. Team: (Z3660) <input type="checkbox"/> Maternal <input type="checkbox"/> Newborn	32. Air - Fixed Wing (A00330) <input type="checkbox"/>	33. Air - Rotor (A0040) <input type="checkbox"/>	34. Ground (A0362) <input type="checkbox"/>

FAMILY INSURANCE/THIRD PARTY PAYOR INFORMATION

35. Insured Last Name		36. First Name		37. MI
38. Policy Number		39. Company Name		40. Enrollment Date

AHCCCS INFORMATION:

Member ID#	AHCCCS Eligibility Date:
Plan Enrollment Date:	Plan Name:

The State of Arizona has established a High Risk Perinatal Program (HRPP) to provide transportation services for high-risk pregnant women in Arizona. This program also assists families, when needed, to cope with catastrophic costs related to emergency transports.

I am requesting participation in the High Risk Perinatal Program for any necessary transport. I am requesting financial assistance, if needed, and I understand that the HRPP is the payer of last resort. I authorize the release of any necessary medical records, social and financial information held by any institution or individual that provided services to me to the Arizona Department of Health services (ADHS) and to their contracted providers for provider quality management purposes. I agree to submit all necessary documents on behalf of myself for purposes of collection from third party payers and shall retain no insurance proceeds from claims intended as payment for services provided.

Diagnosis/Reason for Transport _____

Patient /Responsible Party Signature _____ DATE _____

I certify that this participant meets the medical criteria of the HRPP: _____

Transport Nurse Signature *Date*