# Transportation Authorization Form

**Type of Service (Select One)**

☐ ALS Ambulance ☐ Non-Medical Stretcher ☐ Ambulette

☐ BLS Ambulance ☐ Wheelchair

**Is the Patient Bariatric? (Select One)**

☐ No ☐ Yes If yes, what is the patients weight?_____

**Patient Information:**

Name:_____ Date of Birth:_____

Does the patient have Medicaid? ☐ No ☐ Yes

**Trip Details:**

Date of Service:_____ Round Trip: ☐ No ☐ Yes

Appointment time(s):_____

Pick-up Address: _____

_____

Drop-off Address:_____

_____

**Payment Authorization:**

Quoted Price of Service:_____

*****Person signing below is an authorized facility representative and is guaranteeing payment*****

Authorized Personnel's Name:_____

Authorized Personnel's Signature:_____

Facility Name:_____ Date:_____

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