



## Prior Authorization for Fixed Wing Air Ambulance Transportation

Fax completed forms to (952)853-8714. Call Utilization Management (UM) at (952)883-6333 with questions. Incomplete forms will be returned. [Submit clinical documentation](#) to support your request. Sign in at [healthpartners.com/provider](https://healthpartners.com/provider) and use the Authorizations and referrals link to check the status of your prior authorization request.

### Member information

First Name MI Last Name  
HealthPartners ID # DOB

### Requester information

Form completed by: First Name Last Name  
Your business name  
Your business street address  
Your business city Your business state Your business zip  
Phone\* Fax\*\*

### Current Facility information

Facility name  
Facility street address  
Facility city Facility state Facility zip  
Facility tax ID (claim may be rejected if incorrect)  
Email Phone\* Fax\*\*

### Receiving Facility information

Facility name  Office  Outpatient  Inpatient  
Facility street address  
Facility city Facility state Facility zip  
Facility tax ID (claim may be rejected if incorrect)  
Phone\* Fax\*\*

### Transportation Vendor information

Vendor name  
Vendor street address  
Vendor city Vendor state Vendor zip  
Vendor tax ID (claim may be rejected if incorrect)  
Email Phone\* Fax\*\*

\*Confidential voicemail required

\*\*For outcome notification



Supporting clinical must be submitted with this request

Is the receiving facility the nearest facility capable of treating the member's condition?    yes    no    If no, please explain:

Explain why the member cannot be transported by ground ambulance:

Explain why the member's medical condition requires uninterrupted care and attendance by qualified medical staff during ambulance transport:

Explain the specialty care the member will receive at the accepting facility, that can't be provided where the member is currently receiving care: