

Non-Emergency Medical Transportation (NEMT) for Health Home Services REQUEST FORM

Date: _____

TO NEMT Broker: _____ FAX #: _____

NEMT Broker Look-up: <https://www.hca.wa.gov/assets/billers-and-providers/BrokerByCounty.pdf>

FROM (Care Coordination Organization): _____

Name of Care Coordinator: _____ Phone # _____

Health Home Lead Agency: (Check one)

- | | |
|--|---|
| <input type="checkbox"/> AAADSW | <input type="checkbox"/> Northwest Regional Council |
| <input type="checkbox"/> Amerigroup | <input type="checkbox"/> Olympic AAA |
| <input type="checkbox"/> Community Choice – Action Health Partners | <input type="checkbox"/> Pierce County Human Services (AAA) |
| <input type="checkbox"/> Community Health Plan of WA | <input type="checkbox"/> Pierce County ACH |
| <input type="checkbox"/> Coordinated Care | <input type="checkbox"/> SE WA AAA |
| <input type="checkbox"/> Full Life Care | <input type="checkbox"/> United Health Care |
| <input type="checkbox"/> Molina | |

Section I - Client Information

Last Name _____ First Name _____

ProviderOne ID Number _____ DOB: _____

Transportation Date (mm/dd/yyyy) and *Appointment Time: _____

Pick-up Address (exact address/entrance): _____

Drop-off Address (exact address/entrance): _____

ROUND TRIP (Circle one): YES / NO

Special Needs (e.g. escort; oxygen, wheelchair/oversize wheelchair; etc.): _____

Section II – Certification:

☐ Client is Medicaid Eligible ☐ Client is enrolled with the Health Home Lead selected above

☐ Client needs transportation to an alternate location to receive health home services

Care Coordinator Signature/Date: _____ / _____