

KOOTENAI COUNTY EMS SYSTEM

Transport Request Form

****FAX THIS FORM, PCS FORM, & FACESHEET PRIOR TO TRANSPORT FOR
SCHEDULING PURPOSES ~ 208-930-4259****

Patient	DOB	
Pick up Location	Room #	Pick up Time
Transport Destination	Date of Transport	Appointment Time
Reason for Transfer/Diagnosis	ICD 10 Codes	

Please indicate the needs of the patient DURING transport.

- ☐ IV Medication Administration ☐ Cardiac Monitor ☐ Ventilator ☐ Blood Products
- ☐ IV Infusion by Volume Controlled Pump ☐ Chest Tube Monitoring ☐ CPAP/BiPAP ☐ Intubated
- ☐ Other _____

Person Requesting Transport _____ **Phone Number** _____

- ☐ Primary Insurance, Pre-Authorization Approval # _____
- ☐ Hospice Pay
- ☐ Private Pay - If YES, _____

Responsible Party Name: _____

Responsible Party Billing Address: _____

*Estimated Cost of Transport \$ _____

*I/we the undersigned acknowledges that services provided to the above patient by KCEMSS will be billed to the above responsible party. I/we the undersigned agree to pay for all services rendered by KCEMSS. *This estimated cost is not a guarantee of cost for services. The above estimate is based on unconfirmed information from facility or patient and therefore may need to be adjusted if the information is not accurate.*

Name (Print) _____ Signature _____ Date _____

Kootenai County Emergency Medical Services System • 208-930-4224 • Fax 208-930-4259



To provide exceptional, compassionate and innovative medical care and service to the citizens and visitors of Kootenai County.