

## Medical Certification for BLS/ALS Transportation

The member's medical provider must complete this form to verify the medical necessity of Basic Life Support (BLS) or Advanced Life Support (ALS) transportation.  
Once complete, please fax, email, mail or submit the completed form online through the chat feature.

<b>Patient Information</b>	First Name	Last Name	DOB	Health First Colorado ID #
	<b>Medical Facility Information</b>			
Facility Name				
Facility Address (Street Address / City / State / Zip)				
Medical Provider's Name & Title				
Contact Name & Title				
Contact Phone			Contact Email	
<b>Type of Transport Requested:</b> <input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/> Stretcher Van				
<b>Reason Patient requires BLS or ALS transportation</b> (attach additional documentation, if necessary)				
<b>Medical Provider Attestation</b>	I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.			
	Printed Name of Facility Staff		Title	
	Signature of Facility Staff		Date	
<b>Term of Verification</b>	For an indefinite Term?	<i>If not</i>	From:	To:

Please send completed form to: Fax (720) 302.0106 | Email: [us.coclinicalcoordinator@transdev.com](mailto:us.coclinicalcoordinator@transdev.com)