IntelliRide by transdev

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.

Patient Information	First Name	Last Name	DOB	Health First Colorado ID #
Medical Facility Information	Facility Name			
	Facility Address			
	Medical Provider's Name & Title			
	Contact Name & Title			
	Contact Phone	Contact Email		
Reason Patient requires BLS or ALS transportation (attach additional documentation, if necessary)				
Medical Provider Attestation	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	
Term of Verification	For an indefinite Term?	*If not*	From:	To: