COLORADO
Department of Health Care Policy & Financing

Non-Emergent Medical Transportation (NEMT) Prior Authorization Request (PAR)

Complete this form to request authorization for NEMT service for members needing services out of state.

Provider Request

This NEMT request form must be completed by a medical professional. Medical necessity attesting that the services are unavailable in Colorado must be attached.
Do not submit this form before an accepting provider has been established to care for the member.

Requesting Provider

Name (First, Middle, Last, Suffix)	Phone number	Email
Organization name	Title	

Members under the following programs **do not qualify** for NEMT services:

- Old Age Pension – State Medical Program (OAP SMP)
- Qualified Individual – 1 Medicare (QI-1)
- Qualified Medicare Beneficiary (QMB)
- Special Low-Income Medicare Beneficiary (SLMB)
- Child Health Plan *Plus* (CHP+)

Member Information

Name (First, Middle, Last, Suffix)		Date of Birth
Age	Health First Colorado ID Number	

Does the member have a PAR for the services being performed? ◯ Yes ◯ No

If yes, PAR number: _____

Is this member being referred to an Indian Health Services provider? ◯ Yes ◯ No

Does the member have commercial insurance? ◯ Yes ◯ No

Commercial insurance name: _____

Did the commercial insurance approve this treatment? ◯ Yes ◯ No ◯ N/A

If yes, a copy of the commercial insurance approval must be submitted with this request.

Commercial insurance approver's contact information: _____

Does the member have Medicare? ◯ Yes ◯ No Medicare ID Number _____

Is the member in the custody of the state? ◯ Yes ◯ No

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Travel Information

Date of Scheduled appointment/treatment	Requested departure date	Requested return date

Meals requested? ◯ Yes ◯ No Lodging Requested? ◯ Yes ◯ No Escort Required? ◯ Yes ◯ No

Type(s) of transportation requested:

- ☐ Personal Vehicle
- ☐ Out-of-state commercial airline
- ☐ In-state commercial airline
- ☐ Air Ambulance

Treatment Information

1. What service treatment is being requested? _____

2. Will the care be inpatient or outpatient? _____

(Note: All out-of-state inpatient hospital admissions require a PAR)

3. Colorado referring provider (name, provider group, location): _____

_____ Referring provider NPI: _____

4. Referring provider or case manager: Contact phone: _____

Contact email: _____

5. Accepting provider name: _____ NPI: _____

6: Accepting provider: Contact phone: _____

Contact email: _____

7. Accepting facility name and location: _____

Provide a brief description as to why this service is being performed outside of Colorado.

_____

_____

_____

Email completed NEMT request form to outofstateNEMT@state.co.us.

I attest I have filled this form out in its entirety.

Signature: _____

Date: _____

Revised October 2021