Partner Tip Sheet

Prior Authorization of Repetitive, Scheduled Non-Emergency Ambulance Transport

Prior authorization is when a doctor or health care provider asks for permission from Medicare before providing certain medical services or items. They do this to make sure the care is necessary and covered by Medicare before it's provided.

Medicare runs a prior authorization program for people with Original Medicare (Part A (Hospital Insurance) and Part B (Medical Insurance)) who get repetitive, scheduled non-emergency ambulance transport. Medicare covers ambulance services only when medically necessary.

Who does this program affect?

This program may affect people with Medicare if:

- They get repetitive, scheduled, non-emergency ambulance transportation (3 or more round trips in a 10-day period or at least once a week for 3 weeks or more).
- They get this transportation from any ambulance company nationwide.

Note: If all program requirements aren't met, the person may be billed for ambulance services even if they haven't signed an Advance Beneficiary Notice of Noncoverage.

How does this program work?

The person or the ambulance company may send a request for prior authorization along with supporting documentation to Medicare.

A Medicare contractor will review the information, and Medicare will cover this transportation if the contractor decides the services meet all of Medicare's requirements.

If the request isn't approved, the person or the ambulance company may submit another prior authorization request before submitting the claim with more information that supports the need for the transportation.

Note: This prior authorization program hasn't changed what people and Medicare pay for repetitive, scheduled non-emergency ambulance transport. This program requires the same information currently necessary to support Medicare payment, just earlier in the process.

What's the goal of this program?

The goal is to make sure that people with Medicare continue to get medically necessary care while cutting costs and minimizing incorrect payments.

What actions does the person with Medicare need to take?

In most situations, the ambulance company will send the prior authorization request to Medicare, and Medicare will let both the company and the person with Medicare know its decision within 7 calendar days of getting the request. If the prior authorization is approved and the transportation is covered, the person with Medicare should only need to pay the deductible and coinsurance. In limited situations, the person with Medicare may need to submit the prior authorization request and supporting information.

Where can a person get help with alternative transportation?

They can contact the ElderCare Locator at 1-800-677-1116 or **eldercarelocator@usaging.org**, or their local State Health Insurance Assistance Program (SHIP) if they need help finding transportation services. Visit **shiphelp.org** to find your local SHIP and get free personalized help.

If the person has Medicaid or belongs to a Program of All-inclusive Care for the Elderly (PACE), they can contact these programs to find out if they qualify for help with transportation coverage.

Where can I get more information?

- For more information on ambulance services coverage, visit **Medicare.gov/coverage/ambulance-services**, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- For more information on the prior authorization program, email **ambulancePA@cms.hhs.gov**.

Medicare

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