Handling 405T Requests – Transportation with Special Medical Needs

1. Receive the Call

- Call center agent receives transportation request.
- Determine if request involves **special medical needs**:
  - Stretcher
  - Oxygen
  - Ventilator
- Check internal provider availability.

2. No In-Network Provider Available

- If **no provider** is available who can accommodate the request:
  - **405T Form**
  - **Send** the form to:
    - The **Caseworker**
    - **CC:** Dulce(dgonzalez@gobhi.org) and 405t@gobhi.org

3. Hospital Caseworker Responsibility

- **Hospital discharge staff** (Caseworker) must:
  - Complete the sections: **" Client & Trip Information"**
  - Identify the accepting **external transportation provider that has availability to complete this transport**
  - **Fill out the Transportation Provider information and email form back to** 405t@gobhi.org **for review**.

4. Review & Approval

- Upon receiving the completed form:
  - The appropriate internal team **reviews** the request.
  - If all sections are properly completed and conditions are met, the request is **approved**.

Notes

- Ensure all emails related to the 405T form are sent to 405t@gobhi.org
- Follow up within 24 hours if no response is received from the caseworker or provider.
- Keep a record of the form and communication in the client's file.

Oregon Health Plan Transportation Order

To be completed by Transportation company Transportation provider name			Provider number
Phone number:	Fax number:	Name of authorizing brokerage:	

To be completed by hospital discharge staff **Client information**

Name: *(Last, First)*		Phone number:	OHP ID #
Pick-up street address:		Apt #	City
Pick-up location's type and name *(Client's home, long term care facility, hospital, etc.)*			

To be completed by hospital discharge staff **Trip information**

Mode: ☐ Ambulance ☐Other (specify):		Trip Info: ☐ 1-way ☐ Round trip ☐ 3-way	
Destination 1 *(Dr/Clinic name)*		Destination 1 address:	
Destination 1 phone:	Appt. date:	Appt. time: ☐ a.m. ☐ p.m.	Pick-up time: ☐ a.m. ☐ p.m.
Destination 2 name		Destination 2 address:	
Destination 2 phone:	Appt. date:	Appt. time: ☐ a.m. ☐ p.m.	Pick-up time: ☐ a.m. ☐ p.m.
Days needed *(for ongoing trips - check all that apply):* ☐Sun. ☐Mon. ☐Tues. ☐ Wed. ☐ Thurs. ☐Fri. ☐Sat.		Pick-up time: ☐ a.m. ☐ p.m.	Return time: ☐ a.m. ☐ p.m.
Reason for ambulance transport - Enter the medical reason (*e.g.,* use of ventilator or constant IV):			

Authorization: To be filled out by GOBHI staff only. Clients do not need to fill out any of the below information or send it in.

If approved, send the completed form to the Provider Services Unit by secure email, fax or mail. Also send a copy of the completed form to the requesting transportation provider.

- **Email:** Send a scan of the form to dmap.providerservices@state.or.us (put "405T" in the subject line).
- **Fax:** 503-945-6873 (Salem)
- **Mail:** Provider Services, ATTN: 405T, 500 Summer St NE E44, Salem OR 97301

Is the trip to access a Medicaid-covered service? ☐ Yes ☐ No	If yes, enter initials of brokerage staff who verified the trip:
Dollar amount authorized: Enter the approved bid price (if above OHP fee schedule). Trip will be paid per OHP fee schedule unless special circumstances warrant additional payment:	
Special circumstances: If amount authorized is above OHP fee schedule, explain why this cost was approved.	

Brokerage authorization – *This section must be signed by the brokerage staff authorizing transport.*

Authorizing staff name: ______________________ Phone number: ______________

______________________ ______________

Signature Date

Distribution: 1 copy to provider, to retain; 1 copy for brokerage, 1 copy to Provider Services