Request for Quote – Ambulance Service

Complete this form to request a service quote. Do not include any PHI.

Requesting Organization / Contact

Requesting Organization / Facility Name (Required)

Department

Contact Person (Required)

Phone (Required)

Email (Required)

Service Details

Type of Service Requested (choose one)

- ( ) BLS
- ( ) ALS
- ( ) CCT
- ( ) Wheelchair Van
- ( ) Other

If 'Other', please specify

Transport Type

- ( ) Emergency
- ( ) Non-Emergency
- ( ) Standby / Event Coverage

Pick-up Location (General – no patient names)

Destination (General – no patient names)

Estimated Date & Time of Service

Special Requirements (check all that apply)

- [ ] Bariatric Transport
- [ ] Oxygen / Ventilator Support
- [ ] Monitor/Defibrillator
- [ ] Two-person Stretcher Team
- [ ] Other

If 'Other' special requirement, please specify

Frequency of Service

- ( ) One-time transport
- ( ) Recurring / Scheduled transports

If Recurring: Frequency (e.g., daily, weekly, monthly)

If Recurring: Duration (Start & End Dates)

Billing Information

Billing Contact Name

Billing Phone/Email

Billing Address