PhysicianCertification Form-RequestforTransportation

Please print clearly and have physician sign this form where indicated below.
*These are the fields required for the form to be accepted.

PATIENT INFORMATION	
*Patient's Name:	*Patient's DOB:
*Patient's ID Number/CIN#	Member's Contact Number:
DIAGNOSIS	
Diagnosis:	ICD Code:

MODE OF TRANSPORTATION NEEDED (*Please check ONLY ONE level of service in either NEMT or NMT section)

Non-MedicalTransportation (NMT)
NMT includes transportation for medical appointments and may be provided via taxi or sedan or other public conveyances. NOTE: Non-Medical Transportation does not require a physician's signature. Check the applicable level of service needed:

- ☐ Mass Transit
- ☐ Paratransit
- ☐ Ambulatory Passenger car /Sedan Taxi
- ☐ Ambulatory Door-to-Door
- ☐ Private Vehicle arranged by patient*

Non-Emergency Medical Transportation (NEMT)
NEMT includes ambulance, wheelchair, and gurney vans that are provided when medically necessary, specifically when the patient is non-ambulatory. Check the applicable level of service needed:

- ☐ Wheelchair Van
- ☐ Ambulance/Litter Van/Gurney Van (Patient bed bound)
- ☐ ALS (Patient requires ALS services/availability)
- ☐ CCT/SCT (Patient requires cardiac monitoring)
- ☐ LS (Patient requires oxygen not self-administered or regulated)
- ☐ Air Transport

**additional verification information needed for approval*

*DURATION (based on medical necessity and continued health plan eligibility):
Start Date of Service:
End Date of Service:

FUNCTION LIMITATIONS JUSTIFICATION

When transportation is requested for an ongoing basis, the chronic nature of the recipient's medical, physical, or mental health condition must be indicated and treatment plan. A diagnosis alone will not satisfy this requirement. The physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles. **NMT services will be approved based on the least costly method of transportation that meets the member's needs.**

***PLEASE INCLUDE YOUR JUSTIFICATION BELOW:**

***CERTIFICATION**

The physician, dentist, podiatrist, mental health or substance use disorder provider responsible for providing care for the member is responsible for determining medical necessity for transportation. The prescribing physician's statement is certifying that medical necessity was used to determine the type of transportation being requested. This certification can be completed and signed by an MD, PhD, LVN, RN, PA, NP, LCSW, LMFT, BCBA or discharge planner who is employed or supervised by the hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certification. Authorizations may be for a maximum of 12 months.

Staff/Physician's Name (Print):	Date:
Staff/Physician's Signature:	Phone Number:

Please return form by facsimile to ModivCare - Attn: Utilization Review (877) 457-3352