

Physician Certification Statement Form - Request For Transportation

THIS FORM MUST BE COMPLETED IN FULL AND SIGNED OR IT WILL NOT BE PROCESSED

The purpose of this form is for physicians to communicate to Modivcare[™] specific transportation restrictions of a patient/member due to a **medical condition**. The restrictions and requirements stated on this form will be used by Modivcare to assign the best means of transportation for the patient/member.

THEREFORE, THE STATEMENTS MADE BY PHYSICIANS REGARDING PATIENT TRANSPORTATION RESTRICTIONS ARE MADE UNDER PENALTY OF MEDICAID FRAUD.

Patient name: ___

Patient ID #/CIN #:	Patient DOE	3:/	
If the patient requires NEMT , refer to page Then, select one of the following:	2 to determine the med	ically necessary mo	de of transport.
☐ Gurney/litter/stretcher van ☐ BLS ambu☐ Air transportation ☐ Wheelchair van	lance □ ALS ambulance	e □ Critical care tran	nsport
These services require physician justification	า and signature below.		
Duration of services (based on continued	health plan eligibility):		
Start Date: ☐ 60 days ☐ 90	days □ 180 days □ 3	365 days (Chronic cor	ndition only)
Transportation under Medi-Cal is covered only what travel by bus, passenger car, taxi, or other form of patient's limitations and provide specific physical ambulate without assistance or be transported by patient from traveling by bus, passenger car, to	f public or private conveyand and medical limitations that p public or private vehicles. P	ce. The physician is requoreclude the patient's ablease document below:	uired to document the bility to reasonably What prevents the
The physician, dentist or podiatrist responsible for necessity for transportation. This certificate can be independent practice association (IPA), primal substance use disorder provider, certified mit hospital, facility or physician's office where that the time of completion of this certificate.	oe completed and signed by ary care physician (PCP), N idwife, or discharge planne	participating physicia MD, LVN, RN, PA, NP, r er who is employed or su	n group (PPG), mental health provider upervised by the
Staff/physician's name (print):			
Staff/physician's signature:	Title:		
Date:	Contact pho	one: ()	-
Please return form by fax to Mo	divcare, Attention: Utilizat	ion Review at 877-457	-3352.

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Description of transportation services		
Gurney/litter/stretcher van	Patient is confined to a bed and cannot sit in a wheelchair but does not require medical attention or monitoring during transport.	
BLS ambulance	Patient is confined to a bed, cannot sit in a wheelchair, and requires medical attention or monitoring during transport for reasons, such as:	
	Isolation precautions.Non-self-administered oxygen.Sedation.	
ALS ambulance	Patient is confined to a bed, cannot sit in a wheelchair, and requires medical attention or monitoring during transport for reasons, such as: • IV requiring monitoring. • Cardiac monitoring. • Tracheotomy.	
Critical care transport	Patient has a special condition that requires the presence of a critical care nurse or a medical doctor during transport.	
Air transportation	Requires prior authorization from the plan.	
Wheelchair van	Patient is a wheelchair user and requires lift-equipped or roll-up wheelchair vehicle.	