AUTHORIZATION

Return to: Utilization Management
Phone: 1-408-874-1821
Fax: 1-408-874-1957 or 1-408-376-3548

Authorization for Transportation Services and Physician Certification Statement

INSTRUCTIONS
The physician, dentist, podiatrist or mental health or substance use disorder provider responsible for providing care for the member is responsible for determining medical necessity for transportation.

PATIENT INFORMATION			
Patient's Name:			Patient's DOB:
Patient's ID Number/CIN#:			Member's Contact Number:
Address:			Caregiver Name:
City:	State:	Zip:	Caregiver Contact Number:
DIAGNOSIS (Must support need for transportation)			
Diagnosis:			ICD 10 Code:
Diagnosis:			ICD 10 Code:

MODE OF TRANSPORTATION NEEDED			
☐ **Non-Emergency Medical Transportation (NEMT)** Non-emergency Medical Transportation is available to obtain medically necessary services when the patient's medical/physical condition does not allow them to travel by bus, passenger car, taxicab or other forms of public or private conveyance.			
☐ Ambulance	☐ Wheelchair Van	☐ Gurney Van/Litter	☐ Air
Transportation Company:			
Phone number:		Fax Number:	

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DATES OF SERVICE NEEDED

☐ One-Time Only Date: ______________	☐ Ongoing (up to 12 months) Start Date: ___________ End Date: _____________

FUNCTION LIMITATIONS JUSTIFICATION

Please document the patient's limitations and provide specific physical and medical limitations that preclude the patient's ability to reasonably ambulate with assistance or be transported by public or private vehicles.

Treatment plan should include the medical, behavioral health, or the physical condition that prevents normal public or private transportation:

☐ Request is for multiple transports that are ongoing to the same provider for same chronic diagnosis; treatment plan is attached.

☐ Request is for multiple transports that are ongoing to different providers for any covered services. This includes minors accessing EPSDT covered services. Treatment plan is attached

☐ Hemodialysis – Standing order, covered for 6-month period with unlimited trips.

☐ Other - Explain:

CERTIFIED BY:

I certify that medical necessity was used to determine the type of transportation requested.

Staff/Physician's Name: (print)	Date:
Staff/Physician's Signature:	NPI:
Phone Number:	Fax Number: