PROVIDER MEMO

To: Santa Clara Family Health Plan Providers

From: SCFHP Utilization Management

Date: December 15, 2022

Subject: Updated Physicians Certification Statement (PCS) Form

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Dear SCFHP provider:

Effective January 1st, 2023, all Non-Emergency Medical Transportation (NEMT) prior authorization request will be required to be on the revised Physicians Certification Statement (PCS) form.

Santa Clara Family Health Plan has updated our PCS form to meet regulatory requirements from the Department of Health Care Services (DHCS). The form must be filled out in its entirety and signed in order to be processed. Please fax the completed PCS form to SCFHP Utilization Management Department at 1-408-874-1957.
If there is a current approved authorization on file, a new PCS form is not needed until the authorization is about to expire.

You can download the new fillable Prior Authorization - PCS form on our website at www.scfhp.com under “forms and documents” for providers.

If you have questions about the new PCS form, please contact SCFHP Provider Network Operations at 1-408-874-1788.

Santa Clara Family Health Plan™

AUTHORIZATION FORM
Return to: Utilization Management
Phone: **1-408-874-1821**
Fax: **1-408-874-1957**

Physician Certification Statement (PCS) Form

Patient/Member Information			
Full Name:			SCFHP ID:
DOB: Month	Day	Year	Phone Number:
Address:	City:	State:	Zip:

Mode Of Transportation Needed

☐ **Non-Medical Transportation (NMT)**

Non-Medical Transportation is travel by bus, passenger car, taxicab or other forms of public or private conveyance. A PCS form is not required. Member may contact Customer Service to arrange ride.

☐ **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.

Please check all applicable modalities, multiple modalities may be requested:

☐ **Ambulance** (check all that apply)**:**

- ☐ Transfer between facilities that requires continuous intravenous medication, medical monitoring, or observation
- ☐ Transfer from an acute care facilities to another acute care facility
- ☐ Transport for member who has recently been placed on oxygen (does not apply to members who carry their own oxygen for continuous use)
- ☐ Chronic conditions requiring oxygen and medical monitoring

☐ **Litter/Gurney Van** (check all that apply)**:**

- ☐ Requires prone or supine position; incapable of sitting for the period of time needed to transport, and requires specialized safety equipment over and above what is normally available in passenger cars, taxicabs, or other forms of public transportation
- ☐ Post-operative, stable members who cannot tolerate sitting upright for the time required for transport from pick-up point to destination
- ☐ Bed Bound
- ☐ Spica cast

☐ **Wheelchair Van** (check all that apply)**:**

- ☐ Requires wheelchair or assistance to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation
- ☐ Severe mental confusion
- ☐ Paraplegia
- ☐ Dialysis recipient
- ☐ Chronic conditions requiring oxygen, but do not require monitoring

☐ **Air Transport**

Diagnosis (Must support the need for Non-Emergency Medical Transportation)	
Diagnosis:	**ICD 10 Code(s)**:
Function Limitations Justification (Required) 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.	

Date(s) of Service Needed:	
☐ One-Time Only Date:	☐ Ongoing (up to 12 months) Start Date: End Date:

Certified By:	
I, *the member's physician, dentist, podiatrist or mental health or substance use disorder provider responsible for providing medical care to the member*, certify that medical necessity was used to determine the type of transportation requested.	
Physician/Provider's Name:	
Physician/Provider's Signature Date:	
NPI:	
Phone Number:	Fax Number: