Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)
PRESCRIPTION / ATTESTATION OF MEDICAL NECESSITY

In order to process your request, complete all form fields below including physician signature and date of signature. **If any field is incomplete, the request cannot be processed and may result in delay of service.** This form constitutes a prescription and attestation of the medical necessity for transportation services. Ventura Transit Service (VTS) requires at least 48 hours prior notice for all standard requests. Please submit this form in a timely manner to allow for verification of the information provided below.

1. Member Name: ______________________ 2. GCHP ID Number: ______________________

3. Member's Preferred Contact Number: ______________________ 4. GCHP Member DOB: ______________________

4. Servicing Provider / Facility: ______________________ 6. Language Preference: ______________________

7. Date of Service (DOS) for Authorization. (Not to exceed one year and dependent on member eligibility.)

From: ______________________ To: ______________________

8. Days of the week transported to above appointment(s):

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ Varied

9. Caregiver will accompany: ☐ Yes ☐ No Reason: ______________________

10. Diagnosis:

11. Medical purpose / justification for visit(s):

12. Patient mobilizes via: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Bed bound ☐ Other (describe) ______________________

13. Mode of transportation requested: ☐ Ambulance ☐ Wheelchair van ☐ Lifter van ☐ Air ☐ Other (describe) ______________________

14. Beneficiary functional limitations (specific physical or mental) that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance:

☐ Wheelchair bound and unable to self-transfer
☐ Mental confusion
☐ Respiratory disorder
☐ Other (please describe): ______________________
☐ Hemodialysis
☐ Visual impairment

15. ☐ Unable to use private or public transportation due to medical condition.

By signing this form, Provider acknowledges that medical necessity was used to determine the type of transportation being requested.

16. Provider Name: ______________________ 17. Date: ______________________

18. Provider Signature: ______________________ 19. License Number: ______________________

20. Office Contact Name: ______________________ 21. Phone: ______________________

22. Provider Specialty: ______________________ 23. Fax: ______________________

24. Provider Address (number, street, city, zip code): ______________________

PROVIDER: Please FAX completed form to GCHP at: 1-855-883-1552