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 DOB: _____/_____/_____

If the patient requires **NEMT**, **refer to page 2 to determine the medically necessary mode of transport.** Then, select one of the following:

☐ Gurney/litter/stretcher van ☐ BLS ambulance ☐ ALS ambulance ☐ Critical care transport
☐ Air transportation ☐ Wheelchair van

These services require physician justification and signature below.

Duration of services (based on continued health plan eligibility):

Start Date: _____ ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (Chronic condition only)

Justification

Transportation under Medi-Cal is covered only when the patient's medical and physical condition does not allow him or her to travel by bus, passenger car, taxi, or other form of public or private conveyance. The physician is required to document the patient's limitations and provide specific physical and medical limitations that preclude the patient's ability to reasonably ambulate without assistance or be transported by public or private vehicles. Please document below: **What prevents the patient from traveling by bus, passenger car, taxi, or other form of public or private conveyance?**

Certification

The physician, dentist or podiatrist responsible for providing care for the patient is responsible for determining medical necessity for transportation. This certificate can be completed and signed by **participating physician group (PPG)**, **independent practice association (IPA)**, **primary care physician (PCP)**, **MD**, **LVN**, **RN**, **PA**, **NP**, **mental health provider, substance use disorder provider, certified midwife**, 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 certificate.

Staff/physician's name (print): _____

Staff/physician's signature: _____ Title: _____

Date: _____ Contact phone: (_____) _____ –_____

Please return form by fax to Modivcare, Attention: Utilization Review at 877-457-3352.

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.