

Referral for Transportation Services and Physician Certification Statement

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 Code
Diagnosis	ICD Code

BENEFITS: Medi-Cal CMC Non-emergency transportation is available to obtain MediCal or Medicare covered service 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.
 LACC PASC-SEIU Non-emergency transportation via ambulance is **only** covered for facility to facility or facility to home.

LEVEL OF SERVICE FOR TRANSPORTATION NEED

<input type="checkbox"/> Non-Emergency Medical Transportation (NEMT) NEMT includes ambulance, wheelchair, and gurney vans that is provided when medically necessary, specifically when the patient is non-ambulatory.			<input type="checkbox"/> Non-Medical Transportation (NMT) NMT includes transportation for medical appointments and may be provided via taxi or sedan or other public conveyances		
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Wheelchair Van <input type="checkbox"/> Door to door <input type="checkbox"/> Curb to curb	<input type="checkbox"/> Gurney Van: <input type="checkbox"/> Door to door <input type="checkbox"/> Curb to curb	<input type="checkbox"/> Taxi:	<input type="checkbox"/> Sedan :	<input type="checkbox"/> Sedan: Door to Door <input type="checkbox"/> Sedan: Curb to curb <input type="checkbox"/> Assistive Devices: (circle) Walker- Cane- Crutches

ANTICIPATED DURATION		
<input type="checkbox"/> One Time Only	<input type="checkbox"/> 3 Months Interval	<input type="checkbox"/> 6 Months Interval *Provide justification if applicable

***JUSTIFICATION (When transportation is requested for an ongoing basis, the chronic nature of the recipient's medical or physician condition must be indicated and a treatment plan must be included. A diagnosis alone will not satisfy this requirement)**

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

- Not applicable; request is for a single transport for a routine visit or one-time event
- 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 the 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:

ADDITIONAL FACTORS Indicate the reason for the request for transportation

<input type="checkbox"/> Unexpected Hardship (primary means of transportation unavailable)	<input type="checkbox"/> Geographical Issue (no public transportation in area; traveling time on public transportation greater than 2 hours)	<input type="checkbox"/> Lack of social support (No means of transportation; homeless or resides in shelter)
--	--	--

Details:

CERTIFICATION

The physician, dentist, or podiatrist responsible for providing care for the member is responsible for determining medical necessity for transportation. This certificate can be completed and signed by an MD, LVN, RN, PA, NP 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.

REQUEST SUBMITTED BY:

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

Please return form by facsimile to L.A. Care Attn: **Utilization Review Transportation Unit (877) 457-3352.**