REFERRAL FORM FOR TRANSPORTATION SERVICES AND PHYSICIAN CERTIFICATION STATEMENT (PCS)

The Department of Health Care Services (DHCS) requires that a PCS form is used to process and determine the appropriate level of Non-Emergency Medical Transportation (NEMT) services. Completed and signed forms must be promptly submitted for ***Prior Authorization*** to **Attn: L.A. Care Health Plan's (L.A. Care) Utilization Review (UR) Transportation Unit** via **fax to: 213-438-2201**. If you have questions, please call the Health Services Department at L.A. Care Health Plan by dialing 877-431-2273 and select option 4 for transportation.

***Incomplete forms will faxed back for information**

***Patient Information Required**

First Name:	Last Name:		Date of Birth:
ID Number / CIN#:			Phone Number:
Address:			Caregiver Name:
City:	State:	Zip:	Caregiver Phone Number:

***Requesting Provider Information Required**

Provider Full Name and Title (Print):		
Email :		
Phone Number:	Fax Number:	Provider NPI:

NEMT – PROVIDER CERTIFICATION, JUSTIFICATION & SIGNATURE REQUIRED

Disclaimer: L.A. Care is required to authorize the lowest cost type of NEMT services that is adequate for the Member's medical needs. Once the PCS is submitted, L.A. Care cannot modify without a new PCS form from the Provider.

***NEMT Vehicle Type & Door-Through-Door Required**

☐ **Ambulance:**
Select the appropriate reason(s):
- ○ Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
- ○ Transfers from an acute care facility to another acute care facility.
- ○ Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
- ○ Transport for members with chronic conditions who require oxygen if monitoring is required.

☐ **Litter/Gurney Van**
Must Meet **ALL** Reasons:
- ○ Requires member to be transported in prone or supine position because member is incapable of sitting for the period of time needed to transport.
- ○ Requires specialized safety equipment over and above that normally available in passenger cars, taxis or other forms of public conveyance

☐ **Bariatric Gurney**
Must Provide the Following:
HT: _____
WT: _____

☐ **Wheelchair Van**
Select the appropriate reason:
- ○ Member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
- ○ Requires specialized safety equipment over and above that normally available in passenger cars, taxis or other forms of public conveyance
- ○ Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation

☐ **Bariatric Wheelchair**
Must Provide the Following:
HT: _____
WT: _____

☐ **Air Ambulance**

Requires clinical documentation submitted to LA Care UM to determine medical necessity, due to members medical condition or the practical considerations that render ground transportation as not feasible.

***NEMT Anticipated Duration Required**

Dates of Service (Maximum 12 months)	Start Date:	End Date:

***Functional Limitations Required**: Documentation of the member's limitations with specific physical and medical limitations that preclude the Member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

☐ **Physical Limitations** ☐ **Medical Limitations**

Diagnosis Code(s):

Please indicate who is signing this form: Certification Statement: This form **must be signed** by the ☐ physician,☐ physician assistant, ☐ nurse practitioner, ☐ certified nurse midwife, ☐☐ physical therapist, ☐ speech therapist, ☐☐ occupational therapist, ☐ dentist,☐ podiatrist,☐ mental health, or ☐ substance use disorder Provider responsible for providing care to the Member and responsible for determining medical necessity of transportation consistent with the scope of their practice. By my signature, I certify that medical necessity was used to determine the type of transport being requested.

***Signature Required** X _____	**Date:** _____