Form 2015 (4/2015)

Maintain Original in Medical Record

VERIFICATION OF MEDICAID TRANSPORTATION ABILITIES

Patient Name: ______________________ **Patient Date of Birth** __/__/____ **Patient Medicaid Number:** ____________________

Patient Address: ____ **Patient Telephone:** ______________________

1. Can the patient use mass transit? Yes ☐ No ☐ If you checked NO, please proceed to #2.
2. In the left column below, please **check** the medically necessary mode of transportation you deem appropriate for this patient:

☐ **a) Taxi/Livery:** The patient can get to the curb, board and exit the vehicle unassisted, or is a collapsible wheelchair user who can approach the vehicle and transfer without assistance, **but** cannot utilize public transportation.

☐ **b) Ambulette Ambulatory:** The patient can walk **but** requires assistance.

☐ **c) Ambulette Wheelchair:** The patient is a wheelchair user, requires lift-equipped or roll-up wheelchair vehicle **and** assistance.

☐ **d) Stretcher Van:** The patient is confined to a bed, cannot sit in a wheelchair, **and does not** require medical attention/monitoring during transport.

☐ **e) BLS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient.

☐ **f) ALS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring and tracheotomy.

3. If you selected letter **(a-f)** above, please use the space below to justify the corresponding mode of transportation by providing **<u>the following required information:</u>**

a. Enter **all** relevant medical, mental health or physical conditions and/or limitations that impacts the required mode of transportation for this patient.

b. Enter the level of assistance the patient needs with ambulation. (Example – patient requires 2 person assistance, patient requires 1 person assistance etc.)

c. Enter the corresponding housing situations that may impact the patient's ability to access the selected mode of transportation. (Example – wheelchair bound patient resides on the 2nd floor of a building with no elevator)

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4. Is the requested mode of transport **a temporary, long term, or permanent** need of the patient? Please note that "long term" and "temporary" transport is valid only for the time period indicated. Checking the "permanent" or "long term" box may require additional clarification for approval. It is the medical practitioner's responsibility to notify LogistiCare if a change in the enrollee's condition occurs that would necessitate a change in level of service.

☐ **Temporary until** __/__/____ (Date) ☐ **Long Term until** __/__/____ (Date) ☐ **Permanent**

CERTIFICATION STATEMENT: *I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.*

Physician's Name (PRINT)	10-digit NPI #	Date (/ /)	Signature

Hospital/Clinic/Office Name	Hospital/Clinic/Office Address

Name of person who completed this form	Title	Telephone # ( ) -	Fax # ( ) -