california health & wellness

PHYSICIAN CERTIFICATION STATEMENT FORM – Request for Transportation

This form provides LogistiCare or other authorized transportation provider with information on the appropriate level of transportation needed for this Medi-Cal member.

Patient name: ____

Patient ID #/CIN #: ______________________________ Patient DOB: ________/_________/_________

Non-Emergency Medical Transportation (NEMT)

Choose one of the following levels of service:

☐Wheelchair van ☐Gurney/litter van Ambulance: ☐ALS ☐BLS ☐CCT
☐Air transportation (requires prior authorization from the plan)

JUSTIFICATION: NEMT 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.

NEMT requires a function limitation justification. 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.

What prevents the patient from traveling by bus, passenger car, taxi, or other form of public or private conveyance?
____

Non-Medical Transportation (NMT)

NMT includes transportation for medically necessary appointments and may be provided via taxi, sedan, paratransit (such as Access), or fixed-route transportation, such as buses. *No signature is required for NMT*.

Choose one of the following levels of service:

☐Mass (public) transit ☐Paratransit services (patient must qualify for services.) ☐Sedan/taxi (curb-to-curb)
☐Sedan (ambulatory door-to-door) ☐Sedan with folding wheelchair (patient is able to transfer without assistance) (curb-to-curb)

Duration of services (based on continued health plan eligibility): ☐30 days ☐60 days ☐90 days ☐1 Year

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 a participating physician group (PPG), independent practice association (IPA), primary care physician (PCP), MD, LVN, RN, PA, NP, CNM, PT, OT, ST, mental health or substance use disorder provider, 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. PAs, NPs or CNMs may NOT sign this certificate for hospice care or home health care due to restrictions listed below. **NMT services do not require a physician signature and will be approved based on the least costly method of transportation that meets the patient's needs.**

Restrictions: PAs, NPs and CNMs may not sign PCS form for the following covered services due to restrictions in Title 42 of Code of Federal Regulations Section 440.70 for **Home Health Services**, Section 418.00 for **Hospice Care** or any other federal restriction for Medicaid.

Staff/physician's name (print): ____

Staff/physician's signature: ____Title:___________________________________

Date:______________________________ Contact telephone: (______) ______ – ________________

Please return form by fax to LogistiCare, Attention: Utilization Review at 1-877-457-3352.