



**Medical Necessity Form**  
**Delaware Non-Emergency Transportation Services**  
**Facility Department: Telephone 866-469-2824 Fax 877-813-5599**

In an effort to insure every member is transported by the most appropriate means necessary, LogistiCare requires completion of this form. Please complete this form as accurately as possible and fax to the number shown above.

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Member's Medicaid #:** \_\_\_\_\_

- Can Member ambulate without assistance? .....  Yes  No
- Does Member use a walker or cane? .....  Yes  No
- Does Member require a Wheelchair? .....  Yes  No
- Is Member able to transfer (stand and pivot)?.....  Yes  No
- Is Member bedbound (unable to stand and pivot/ambulate/sit upright)?  Yes  No  
 (Must meet all 3 criteria to qualify for stretcher transport)
- Does Member require medical monitoring? .....  Yes  No
- Does Member require O2? .....  Yes  No
- Can Member self-administer his or her own O2? .....  Yes  No
- Is Member able to act as his or her own responsible party? .....  Yes  No
- Will the Member have an escort? .....  Yes  No

**Mode of Transportation Required:**

- Ambulatory -- Taxi/Sedan/Mini Van (No special needs)
- Ambulatory -- Uses Wheelchair (Able to transfer safely in and out of a vehicle)
- Wheelchair Van – Uses Wheelchair (Unable to safely transfer in and out of a vehicle)
- Van Stretcher -- (Bed Confined and does not require any type medical monitoring)
- Stretcher -- (Bed confined requiring some type of medical monitoring)

If requesting wheelchair van, van stretcher or stretcher, please provide the qualifying ICD9 or

Diagnosis: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Physician's Printed Name

\_\_\_\_\_  
 Date

I certify that the above information is true and correct based on my evaluation of this patient, and represent that due to the member's condition he or she requires transport by the mode requested on this form. I understand that this information will be used by LogistiCare and the Department of Medicaid and Medical Assistance (DMMA) to support the determination of medical necessity for services provided, and that I have personal knowledge of the patient's condition at the time of transport.