Physician Certification Form – Request for Transportation

For NEMT only, the physician must sign this form where indicated below. Please print clearly.

Please complete the form and fax it to ModivCare (formerly Logisticare):

ModivCare
ATTN: Utilization Review
Fax Number: **1.877.457.3352**

Fields with a (*) must be completed.

PATIENT INFORMATION	
*Patient Name:	*Patient DOB:
*Patient ID Number/CIN#:	Patient Contact Number:
DIAGNOSIS	
Diagnosis:	ICD Code:

***TRANSPORTATION NEEDS** **(Please check ONLY ONE level of service in either NEMT or NMT section)**	
Non-Emergency Medical Transportation (NEMT) NEMT includes transportation by ambulance, wheelchair, and gurney vans for medically necessary covered services, specifically when the patient is non-ambulatory. Check the applicable level of service needed: ☐ Wheelchair Van ☐ Ambulance/Litter Van/Gurney Van (Patient bed bound) ☐ ALS (Patient requires ALS services/ availability) ☐ CCT/SCT (Patient requires cardiac monitoring) ☐ LS (Patient requires oxygen not self-administered or regulated) ☐ Air Transport	**Non-Medical Transportation (NMT)** NMT includes transportation provided via taxi, car or other public conveyances for medically necessary covered services. *No signature is required for NMT*. Check the applicable level of service needed: ☐ Public Transportation/Mass Transit ☐ East Bay Paratransit ☐ Curb-to-Curb Vehicle Transportation (Taxicab) ☐ Door-to-Door Vehicle Transportation ☐ Private Vehicle arranged by patient* **Additional verification information needed for approval.*

***DURATION** **(Based on medical necessity and continued health plan eligibility)**				
☐ 30 Days	☐ 60 Days	☐ 90 Days	☐ 6 Months	☐ 12 Months

*FUNCTION LIMITATIONS JUSTIFICATION

When transportation is requested for an ongoing basis, the chronic nature of the patient's medical, physical, or mental health condition must be indicated in the treatment plan. A diagnosis alone will not satisfy this requirement. Treatment plan should include the medical, behavioral health, or physical condition that prevents normal public or private transportation. **NMT services do not require physician signature and will be approved based on the least costly method of transportation that meets the member's needs.**

PLEASE INCLUDE YOUR JUSTIFICATION BELOW:

CERTIFICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The provider responsible for providing care for the member is responsible for determining the medical necessity for transportation. This certificate can be completed and signed by a MD, DO, PA, or NP, CNM, Physical Therapist, Speech Therapist, Occupational Therapist, or Mental Health or Substance Use Disorder Provider 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, except for requests relating to hospice or home health services, which must be signed by an MD or DO.

Provider Name & Credential (Print):	
Phone Number:	Date:
Provider Signature:	

Questions? Please call Alliance Transportation Services toll-free at **1.855.891.7171**.