PHYSICIAN CERTIFICATION STATEMENT FORM – REQUEST FOR TRANSPORTATION

THIS FORM MUST BE COMPLETED IN FULL AND SIGNED OR IT WILL NOT BE PROCESSED.

The purpose of this form is for physicians to communicate to ModivCare™ (formerly LogistiCare) specific transportation restrictions of a patient/member due to a **medical condition.** The restrictions and requirements stated on this form will be used by ModivCare to assign the best means of transportation for the patient/member. In an effort to be most efficient with state funding from the people of California, California Health & Wellness Plan embraces a public transit and curb-to-curb first philosophy when selecting the transportation service level.

THEREFORE, THE STATEMENTS MADE BY PHYSICIANS REGARDING PATIENT TRANSPORTATION RESTRICTIONS ARE MADE UNDER PENALTY OF MEDICAID FRAUD.

Patient name: _____

Patient ID #/CIN #: _____ Patient DOB: ____/____/____

Transportation Service Level

Choose ONE of the below

If the patient requires **NMT**,
Refer to page 2 to determine the medically necessary mode of transport.
Then, select one of the following:

☐ Mileage reimbursement ☐ Mass (public) transit ☐ Rideshare ☐ Sedan/taxi (curb-to-curb)
☐ Sedan with assistance (ambulatory door-to-door)*
*Please provide reasoning why door-to-door is needed.

Duration of services (based on continued health plan eligibility):
☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (Chronic condition only)

Door-to-door reasoning: _____

If the patient requires **NEMT**,
Refer to page 2 to determine the medically necessary mode of transport.
Then, select one of the following:

☐ Gurney/litter/stretcher van ☐ BLS ambulance ☐ ALS ambulance ☐ Critical care transport ☐ Air transportation
☐ Wheelchair van*
*This service requires physician justification and signature below.

Duration of services (based on continued health plan eligibility):
☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (Chronic condition only)

Justification

Transportation 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. 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?**

_____

_____

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, 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.

Staff/physician's name (print): _____

Staff/physician's signature: _____ Title: _____

Date: _____ Contact telephone: (_____) _____ –_____

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

Patient Mobility Questionnaire

Please select **public transit** unless the patient requires the following medical attention:

1. Is the patient medically unable to walk ½ of a mile?
2. Is the patient medically unable to use public transportation if accompanied by an aide/companion?

➔ If YES, select **curb-to-curb.**

3. Does the patient use a cane/walker and is medically unable to climb 3 steps?

➔ If YES, select **door-to-door.**

4. Does the patient have a wheelchair and is medically unable to transfer without assistance?

➔ If YES, select **wheelchair van.**

5. Is the patient medically unable to get up from bed without assistance?
6. Is the patient medically unable to sit in a chair or wheelchair?

➔ If YES, select **gurney/litter/stretcher van or appropriate ambulance.**

Description of Transportation Services

Mass transit	Patient needs no assistance in travel and is capable of walking to public transit pick-up/drop-off locations.
Rideshare	Patient can walk and does **NOT** require assistance to and from a vehicle and is capable of locating a rideshare vehicle on their own (like Lyft).
Gurney/litter/stretcher van	Patient is confined to a bed and cannot sit in a wheelchair, but **does not require** medical attention or monitoring during transport.
BLS ambulance	Patient is confined to a bed, cannot sit in a wheelchair, and **requires** medical attention or monitoring during transport for reasons, such as: • Isolation precautions. • Non-self-administered oxygen. • Sedation.
ALS ambulance	Patient is confined to a bed, cannot sit in a wheelchair, and **requires** medical attention or monitoring during transport for reasons, such as: • IV requiring monitoring. • Cardiac monitoring. • Tracheotomy.
Critical care transport	Patient has a special condition that **requires** the presence of a critical care nurse or a medical doctor during transport.
Air transportation	**Requires** prior authorization from the plan.
Sedan with assistance (ambulatory door-to-door)	Patient can walk but **requires** assistance getting to and from a vehicle.
Wheelchair van	Patient is a wheelchair user and **requires** lift-equipped or roll-up wheelchair vehicle.