**Attn: Facilities Department**
**Fx: 877-457-3316**
**Ph: 866-527-9945**

# Closest Provider Certification

*In order to authorize transportation services, please fill out the following information clearly and accurately*:

**1) Patient Name:** _____
*Last,* *First,* *MI*

**2) Patient DOB:** _____
*MM/DD/YYYY*

**3) Patient Medicaid ID Number:** _____
*XXXXXXXXXX-XX*

**3) Patient Phone Number:** _____
*(XXX) XXX-XXXX*

**4) Patient Pick-up Address:** _____
*Street,* *City,* *State, Zip Code,* *County*

**5) Physician Name:** _____

**6) Physician Address:** _____

**7) Name of HMO/DUAL:** _____ **Caseworker:** _____

**9) Total Mileage for One-Way Trip:** _____ **Treatment Type:** _____

**10) If this is not the closest available provider for this treatment type, explain reason(s) for choosing provider:**

_____

_____

*Falsifying information on this document may be construed as fraud and may prevent the client from receiving further transportation services through our offices. If you have any questions, please contact us at the number above. All forms must be returned* ***within 10 business days****.*

_____ _____ _____
*Signature (HMO/MACC Personnel)** *Print Name (HMO/MACC Personnel)* *Date*
* *Stamped signatures will not be accepted*

Modivcare Employee: _____ Site: _____

Denied Trip Service Date: _____ Denied Trip Number: _____