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Maintain Original in Medical Record

VERIFICATION OF MEDICAL TRANSPORTATION ABILITIES

Fax to: 1-866-779-5242

Form must be completed in its entirety or it will not be processed or approved

Patient Name: _____ Patient Date of Birth __/__/____ Patient Medicaid Number:

Patient Address: _____ Patient Telephone: _____

1. Can the patient use mass transit? Yes ___ No ___ If you checked NO, please proceed to #2.
   - Selecting Yes indicates the patient can walk up to 3/4 mile
2. In the left column below, please **check** the medically necessary mode of transportation you deem appropriate for this patient:

☐ a)**Sedan/Van/Taxi:** The patient can get to the curb, board and exit the vehicle unassisted, or is a collapsible wheelchair user who can approach the vehicle and transfer without assistance, **but** cannot utilize public transportation.

☐ b) **Wheelchair Vehicle:** The patient is a wheelchair user, requires lift-equipped or roll-up wheelchair vehicle **and** assistance.

☐**Wheelchair is Manual and the patient cannot transfer out of the wheelchair into a car seat.**

☐**Wheelchair is Electric.**

☐ c)**Stretcher Van:** The patient is confined to a bed, cannot sit in a wheelchair, **and does not** require medical attention/monitoring during transport.

☐ d)**BLS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient.

☐ e)**ALS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring by an EMT during transport for reasons such as IV requiring monitoring, cardiac monitoring and tracheotomy.

3. Is the requested mode of transport **a temporary, long term, or permanent** need of the patient? Please note that “long term” and “temporary” transport is valid only for the time period indicated. Checking the “permanent” or “long term” box may require additional clarification for approval. It is the medical practitioner’s responsibility to notify ModivCare if a change in the enrollee’s condition occurs that would necessitate a change in level of service.

☐**Temporary until __/__/____** (Date)

☐**Long Term (up to 1 year) until __/__/____** (Date)

☐**Permanent**

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4. Please use the space below to justify the corresponding mode of transportation by providing **the following required information:**
   a. Enter **all** relevant medical, mental health or physical conditions and/or limitations that impacts the required mode of transportation for this patient.
   b. Enter the level of assistance the patient needs with ambulation. (Example – patient requires 2-person assistance; patient requires 1-person assistance etc.)
   c. Enter the corresponding housing situations that may impact the patient's ability to access the selected mode of transportation. (Example – wheelchair bound patient resides on the 2nd floor of a building with no elevator)

Physician's Name (PRINT)	NPI #	Date	Signature
Hospital/Clinic/Office Name	Hospital/Clinic/Office Address		
Name of person who completed this form	Title	Telephone #	Fax #