



Physician's Transportation Restriction Form

LogistiCare is contracted with various Plans under the Statewide Medicaid Managed Care (SMMS) program to manage their transportation service. As part of our policy and procedure, members who have a pick-up and drop-off destination 1/4 of a mile or less from a public bus stop are provided bus passes for their medical appointments. If the member below is able to medically use public transportation, please circle YES and fax to (866) 779-5242 .

PATIENT NAME/DOB:

Medically able to ride Public Transportation: circle one YES NO

MEDICAL NECESSITY CRITERIA

1. PATIENT INFORMATION		2. MEDICAL PROVIDER INFORMATION
DOB:	MEDICAID ID #:	MEDICAL PROVIDER'S NAME COMPLETING FORM:
PATIENT NAME (LAST, FIRST, MI):		
STREET ADDRESS:		MEDICAL PROVIDER'S PHONE NUMBER:
CITY, STATE, ZIP CODE:		
PHONE NUMBER:		

3. Patient has physical condition prohibiting use of the public bus system:
Yes: _____ No Additional Information: _____

4a. Patient has cognitive difficulties prohibiting use of the public bus system:
Yes: _____ No Additional Information: _____

4b. If the patient has an escort/attendant during transportation, are they able to utilize the public bus system?
Yes: _____ No Additional Information: _____

5. Physician Comments:

Estimated duration of the necessity. Circle One **30 Days 90 Days 180 Days 365 Days**

0. FALSIFYING INFORMATION ON THIS DOCUMENT MAY CONSTITUTE FRAUD AND IS REPORTABLE TO AHCA WHICH MAY AFFECT THE MEMBER'S TRANSPORTATION BENEFITS. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT LOGISTICARE AT 866-910-7684.

To the best of my knowledge the above information is true, accurate and complete and the required services are medically necessary to the health of the patient.

Name: _____ **Signature:** _____
Date: _____ **Title:** _____

This form should be completed by the attending physician or his staff to confirm medical necessity of the member not being able to use public transportation. Only a licensed medical professional able to certify medical necessity may sign the above form in block 6. Fax back to Modivcare: (866) 779-5242

