modivcare

GA Operations
1640 Phoenix Blvd. Ste. 200
College Park, GA 30349

LEVEL OF SERVICE CERTIFICATION OF MEDICAL NECESSITY

Required for All Patients / Members Using Stretcher Transport

UR FAX # 877-601-0615

PHONE # 800-486-7642

Patient / Member Information:				Medical Provider Information:	
DOB: ___/___/___	Sex M F	Age	Medicaid ID #	Medicaid Provider #	Phone # (
Patient Name (Last, First, MI)				Medical Provider Name & Address	

Nature of Appointment:

LEVEL OF SERVICE REQUIRED BY PATIENT / MEMBER & PRESCRIBED BY MEDICAL PROVIDER

Stretcher ☐ Oxygen: ☐YES ☐ NO; IF YES CAN THE MEMBER ADMINISTER?

The following criteria must be met and applicable to the condition of the patient / Member at the time stretcher services are provided *:(check all that apply)*

__ Bed confined
__ Unable to walk

Estimated duration of level of service: *(check one)* 90 Days (RN) ☐ 1 year (Physician/PA) ☐

If a Registered Nurse signs this form it is valid for 90 days. A physician or physician's assistant may request certification for up to 365 days.

Please describe the Member's disabling physical condition after treatment that makes transportation by stretcher medically necessary (i.e., dialysis, chemotherapy.)

I understand that any falsification or omission of material fact stated may subject me to penalties by the Department of Community Health when submitting letters of medical necessity related to the NET programs. If you have any please contact LogistiCare's Facility Assistance questions Department at **800-486-7642**

I certify that to the best of my knowledge, the above information is true, accurate and complete and the level of service required for the patient's / Member's transport is medically necessary for the patient's / Member's health.

Physician, PA or RN : PRINTED _____

NAME/TITLE: SIGNATURE: **DATE:**

This form should be completed by the attending physician or his designated staff confirming stretcher is necessary as indicated above. Only a Physician, a Physician's Assistant or Registered Nurse, at the direction of a physician my sign the form above.