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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Physician's Medical Necessity Certification
Non-Emergency Transportation Broker Program

This form serves to provide medical necessity for the provision of transportation services for the eligible Medicaid member indicated below. Pursuant to **Section 100.9 Geographic Considerations** of the Georgia Department of Community Health's *Non-Emergency Transportation Broker Program Policies and Procedures Manual*, transportation required for a specific Medicaid reimbursable service located outside of the general geographic access standard for health care services must be medically necessary. After completion and/or review by the attending physician, the physician must sign and date below. Upon proper completion and attestation of this form, no further documentation of medical necessity shall be required by the broker

Medicaid Member's Information

Name: Date of Birth: Medicaid ID #:		
Address:		Apartment:
City:	State:	Zip:

Medical Provider to Be Transported To

Physician / Facility:			
Address:		City & Zip Code:	
Length of time care needed: Permanent [ ] Yes [ ] No	Temporary [ ] Yes [ ] No	Months Estimated _____	GA Medicaid Provider #:

Medical Necessity for Transport

1	This is the closest facility/physician that can provide this treatment/service because the member has one or more of the following needs: Skilled service_____ Language_____ Behavior _____ Treatment _____ Other: _____	[ ] Yes	[ ] No
2	This member has a condition that prevents them from being treated by a nearer physician/facility (i.e., specialty).	[ ] Yes	[ ] No
3	Other (explain)_____ _____ _____		
4	I am unable to attest to medical necessity for the above indicated Medicaid Member to receive treatment at the facility/physician indicated above.	[ ] Yes	

Physician Attestation and Signature/Date

This is to certify that I am a duly licensed physician and that in my professional judgment it is medically necessary for the above Medicaid Member to travel to the above facility/physician for the reasons indicated. I further certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge and that this information will be used by The Georgia Department of Community Health and its authorized agent to support the determination of medical necessity to receive non-emergency transportation services outside the geographical access standards for healthcare services. I understand that any falsification or omission of material fact stated may subject me to penalties by DCH when submitting letters of medical necessity related to the NET program.

_____

Physician's Name (printed)

_____ _____

Physician's Signature **Date**