modivcare

Phoenix 2 Operations
2602 S 47th ST
Phoenix, AZ 85034

HI LEVEL OF SERVICE CERTIFICATION OF MEDICAL NECESSITY

Required for All Patients / Members Using Wheelchair or Stretcher Transport

FAX # 866-475-5745
PHONE # 866-475-5744

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

LEVEL OF SERVICE REQUIRED BY MEMBER & PRESCRIBED BY MEDICAL PROVIDER

Stretcher Transport ☐ Stretcher ☐ Stretcher Van ☐	Wheelchair Transport ☐ Width of Chair

Stretcher Transport is provided only for patients / Members who do not require medical assistance during transport but are non-ambulatory and unable to use a wheelchair. Patients / members using wheelchairs who also require medical assistance during transport should be referred to the appropriate level of ambulance transport.

Medical Equipment Needed	Medical Necessity Criteria	Medical Necessity Criteria (Cont.)
__ Airway monitoring and/or suctioning __ Oxygen __ Ventilator dependent __ Other	__ Bed-confined __ History of existing paralysis/CA __ Decubitus ulcers / Cannot sit safely __ Hip/leg/back precautions / Cannot sit safely	__ Contractures __ Confused/lethargic/comatose __ Cannot support self while seated in a wheelchair for transport distance __ Other_____

Summary of **Patient's / Member's medical** history, including physical exams, laboratory results, and prescriptions, establishing the medical necessity for the prescribed level of service: (Additional documentation may be attached when necessary.)

Estimated duration of Level of Service. *(check one)* 60 Days ☐ 90 Days ☐ Ongoing ☐

Knowingly providing false information on this Certification may constitute fraud and may prevent the patient / Member from receiving further transportation services. If you have any questions please contact **LogistiCare's** Facility Assistance Department at **866-475-5744**

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.

NAME: **SIGNATURE:** **DATE:**

This Certification may be completed and signed only by the **patient's / Member's** attending physician**, physician's assistant or** Registered Nurse to confirm a medically necessary level of service.