LogistiCare Phoenix 2
2602 S 47TH ST
Phoenix AZ 85034

PHYSICIAN'S TRANSPORTATION RESTRICTION FORM

The purpose of this form is for physicians to communicate to LogistiCare specific transportation restrictions of patients due to a medical condition. The restriction and requirements declared by physicians using this form will be used by LogistiCare to determine the best means of transportation for the patient.

Today's Date: _____

Patient Information

Name: _____

Medicaid ID Number: DOB:

Transportation Needs: *(Please check all that applies; must be completed by physician)*

- o This is a Medicaid billable program/appointment is medically necessary. This is the nearest appropriate Medicaid provider
- o Patient is medically unable to walk 1/4 miles
- o Patient is medically UNABLE to be driven by friend or family member.
- o Patient is medically able to use public transportation ONLY if accompanied by a companion (In such case LogistiCare will pay for companion's fare, but does not provide aide/companion)
- o Patient is Paratransit certified
- o Patient is unable to travel "Public Transportation" i.e. Bus or other public mass transit
  Medical Reason(s): _____
- o Patient can only be transported by stretcher and does not need, nor is likely to need immediate medical attention during transportation
  Medical Reason(s): _____
- o Does patient have a wheelchair? Type: Manual / Electric / Scooter (please circle one)
  (*Logisticare does not provide wheelchairs*)
  ***Is patient able to transfer WITHOUT assistance? Yes / No (please circle one)
- o Patient is able to sit up on his/her own
- o Patient uses a cane/walker. How many feet can patient walk using this equipment?_____
- o Patient is medically UNABLE to use public transportation

****Describe the specific medical conditions directly related to the need for a higher level of service other than public transportation (please print):**

_____

Is period of incapacity permanent? Yes / No

If No, expected expiration date of restrictions: _____

Physician Information (Please ensure form is accurate and complete prior to signing)

NAME: _____ TELEPHONE: _____

SIGNATURE OF PHYSICIAN: _____ DATE:_____

Please fax back to: 866-475-5745