Non-Emergency Medical Transportation Physician Certification Statement (PCS)
MEDICAL NECESSITY TRANSPORTATION CRITERIA

health net

Non-Emergency Medical Transportation (NEMT) Request

The Department of Health Care Services (DHCS) requires that a Physician Certification Statement (PCS) form be used to process and determine the appropriate level of Non-Emergency Medical Transportation (NEMT) services. Health Net requires the submission of this PCS form, signed by a qualified provider when requesting NEMT services.

1. This certification is valid for up to one year from the date of the provider's signature.
2. Please fax the completed and signed form to Health Net at: **Health Net's Care Ride Unit at 833-701-0051**
3. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) **do not require the submission of this form**. Members requesting NMT services should be directed to call Health Net's Customer Service Department **at 800-675-6110 and choose the Transportation option.**
4. Any section marked with an "*" is a mandatory section and must be completed prior to sending to Health Net.
5. Please note, Medi-Cal managed care plans (MCP) are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches (wheelchair van).

*Patient Information Required

First name:	Last name:		Date of birth:
ID number / CIN#:			Phone number:
Address:			Caregiver name:
City:	State:	ZIP:	Caregiver phone:

*Requesting Provider Information Required

Provider full name and title (print):		Tax ID:
Phone number:	Fax number:	Provider NPI:

NEMT – PROVIDER CERTIFICATION, JUSTIFICATION and SIGNATURE REQUIRED

No changes can be made by Health Net or the transportation vendor after it has been submitted by the approved provider. Once the PCS form is submitted, neither Health Net nor the transportation vendor can modify without a new PCS form being sent from the physician or other provider.

*Mode of Transportation needed. Check one box below. Refer to page 2 for the medical necessity criteria per mode of transportation

Ambulance type: ☐ Basic Life Support (A0428) ☐ Advance Life Support (A0426) ☐ Specialty Care Transport (A0434)	☐ Litter/gurney van (T2005) If bariatric litter is required, include: Height:____ Weight:____	☐ Wheelchair van (A0130) If bariatric wheelchair is required, include: Height:_____ Weight:_____	☐ Air transport (A0430 or A0431) Requires prior authorization through Health Net

*NEMT Anticipated duration required (based on continued Health Plan eligibility)

Start date: _____ ☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days (chronic condition only)

*Physical and medical limitations related to this request - Please check ALL items that apply

☐ Behavioral issues ☐ Blind ☐ Dementia ☐ Extensive medical support required (e.g., ventilator, IV, oxygen required) ☐ Hemiplegic ☐ Hemodialysis ☐ High fall risk due to: _____(please specify) ☐ Paraplegic	☐ Other (please specify other functional or physical limitations)

*Diagnosis Information

ICD-10 Codes	1.	2.	3.	4.

***Please CHECK the only approved types of providers that can sign this form:**
This form **must be signed** by a ☐ physician ☐ nurse practitioner ☐ physician assistant ☐ certified nurse midwife ☐ dentist ☐ mental health professional ☐ substance use disorder provider

Certification Statement: As the provider responsible for providing care to the member listed above and responsible for determining medical necessity of transportation consistent with the scope of their practice, by my signature, I certify that medical necessity criteria was used to determine the type of transport being requested.

***Signature and title required:**	**Date:**

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<u>DO NOT</u> fax this page back to Health Net – Reference sheet only

Mode of transportation	Criteria
Wheelchair van Must meet one (1) of the bulleted criteria	Wheelchair van services are covered when the patient's medical and physical condition: (A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport. (B) 1. Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation. 2. Local educational agency (LEA) specialized medical transportation services shall not be subject to subsection (a)(3)(B)1. (C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (D) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
Gurney/Stretcher van/ Litter van Must meet both of the bulleted criteria	Litter van services are covered when the patient's medical and physical condition: (A) 1. Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport. 2. LEA specialized medical transportation services shall not be subject to subsection (a)(2)(A)1. (B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. (C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.
Ambulance levels of service (BLS, ALS SCT) Please select correct ambulance type for the member's condition	(A) **<u>Basic Life Support</u>** 1. Transfers between facilities for members who require continuous intravenous medication, medical monitoring, or observation 2. Transfers from an acute care facility to another acute care facility 3. Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use) 4. Transport for members with chronic conditions who require more than 5L of oxygen if monitoring is required 5. Transport from hospital to psychiatric facility (B) **<u>Advanced Life Support</u>** 1. Transport from hospital to hospital with a cardiac monitor (C) **<u>Specialty Care Transport</u>** 1. Transport from hospital to hospital when members require vent, respiratory therapist, or deep suctioning. 2. Transport from hospital to SNF/residence when members require vent, respiratory therapist, or deep suctioning. 3. Transport to an appointment when members require vent, respiratory therapist, or deep suctioning. 4. Transport from hospital to hospital for members that require continuous intravenous medication
Air transport Clinical documentation required	Medical transportation by air is covered under the following conditions: (A) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply: 1. The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1). 2. The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1). (B) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.