ModivCare
4149 Highline Blvd, Suite 200
Oklahoma City, OK 73108

LEVEL OF SERVICE CERTIFICATION

Required for All Clients Traveling by Wheelchair or Stretcher

FAX # 866-697-0497
PHONE # 866-697-0492

Patient Information				Provider Information	
DOB: / /	Sex M F	Age	Medicaid ID #	Medicaid Provider #	Phone # ( )
Patient Name (Last, First, MI)				Provider Name & Address	
Street Address					
City, State, ZIP Code					
Phone #					

MODE OF TRANSPORT REQUIRED BY PATIENT & RECOMMENDED BY DOCTOR

Stretcher Transport ☐	Wheelchair Transport ☐ Ambulatory Transport ☐
ALS ☐ BLS ☐ Stretcher ☐ Oxygen ☐	Width of Chair _____ Oxygen ☐

Stretcher Service is provided only for those patients who do not require medical assistance however cannot sit in a wheelchair. A Wheelchair person requiring medical attention during transport should be referred to the appropriate level of ambulance care.

(Please document all conditions that apply)	Medical Necessity Criteria	(Please document all conditions that apply)
___ Requires Continuous Oxygen Therapy ___ Requires Restraints ___ Requires Restraints (Posey) ___ Physical ___Chemical/Sedation ___ Patient is Comatose	___ Unrepaired/Recent Fracture/Joint Replacement ___ Unable to Bear Weight ___ Requires Continuous IV Therapy ___ Requires Cardiac Monitoring ___ Requires Escort (if checked please specify) ___ Escort Unable to Walk (if checked please specify)	___ Requires Advanced Treatment Specify: ___ Bed Confined ___ Unable to Transfer ___ Unable to Walk ___ Unable to Sit in a Chair or Wheelchair

Summary of history (Physical Examination, Laboratory, X-Ray Studies, Prescriptions) or other applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed level of service. (Additional documentation may be attached when necessary.)

Estimated Duration of This Level of Service. Check One This Trip Only ☐ 30 Days ☐ 90 Days ☐ 180 Days ☐

Falsifying information on this document may constitute fraud and may prevent the client from receiving further transportation services through our office. If you have any questions please contact LogistiCare at **866-697-0492.**

To the best of my knowledge the above information is true, accurate and complete and the required services are medically necessary to the health of the patient.

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

This form should be completed by the attending physician or his staff to confirm Stretcher or Wheelchair is necessary for a specific medical condition. Only a Physician, a Physician's Assistant or RN, at the direction of a Physician may sign the form in the above section.