LogistiCare

Iowa Operations
4149 Highline Blvd. Suite 200
Oklahoma City, OK 73108

LEVEL OF SERVICE CERTIFICATION OF MEDICAL NECESSITY

Required for All Patients / Member Using Wheelchair or Stretcher Transport

FAX # 866-277-8959

PHONE # 866-277-8958

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 #					

LEVEL OF SERVICE REQUIRED BY MEMBER & PRESCRIBED BY MEDICAL PROVIDER

Stretcher Transport ☐	Wheelchair Transport ☐ Ambulatory Transport ☐
ALS ☐ BLS ☐ Stretcher ☐ Oxygen ☐	Width of Chair _____ Oxygen ☐
Weight:____ Height:____ Stairs:__ Ramp: ☐Yes ☐No	Weight:____ Height:____ Stairs:__ Ramp: ☐Yes ☐No

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. Members using wheelchairs who also require medical assistance during transport should be referred to the appropriate level of ambulance transport.

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

Knowingly providing false information on this Certification may constitute fraud and may prevent the Member from receiving further transportation services. If you have any questions please contact LogistiCare's Facility Assistance Department at **866-277-8958.**

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 Member's transport is medically necessary for the 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.

"Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose."