modivcare

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PHYSICIAN'S TRANSPORTATION RESTRICTION FORM

The purpose of this form is for a physician to communicate to Modivcare specific transportation restrictions of a patient / member due to a medical condition.
The restrictions and requirements stated on this form will be used by Modivcare to determine the best means of transportation for the patient / Member.

Today's Date: _____

Patient / Member Information: _____

Name: _____

Medicaid ID Number: _____ **DOB:** _____

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

- ☐ This appointment is for a Medicaid covered service and is medically necessary.
  - ☐ The appointment is with the nearest and appropriate Medicaid provider.
- ☐ Patient /Member uses a cane/walker. How many feet can patient / member walk using this equipment?
- ☐ Patient / Member is medically unable to walk 1/4 mile.
- ☐ Patient / Member is medically unable to be driven by friend or family member.
- ☐ Patient / Member is medically able to use public transportation (e.g., bus or other public mass transit)
  - ☐ ONLY if accompanied by an aide/companion. (If so, Modivcare pays for the aide's/companion's fare, but Modivcare does not provide the aide/companion.)
- ☐ Patient is unable to use public transportation:

**Describe the specific medical condition(s) directly related to the reason patient /member is unable to use public transportation:

_____

Estimated duration of the prescribed restriction is medically necessary for:
☐ **90 Days** ☐ **6 Months** ☐ **1 Year**

Does patient / member have a wheelchair*? ☐ Yes** ☐ No

If yes, Type: ☐ Manual ☐ Electric ☐ Scooter* (**Modivcare does not provide wheelchairs or scooters.*)

**Is patient / member able to transfer without assistance? ☐ Yes ☐ No - Patient is able to sit up on his/her own.

☐ Patient is Paratransit certified.

☐ Patient can only be transported by stretcher and does not need/ is unlikely to need immediate medical attention during transportation.

☐ Medical Reason(s): _____

Physician Information:

NAME: _____ **PHONE:** (_____) _____

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____

*** This form can be completed by a primary care physician (PCP), physician's assistant, physician specialist, nurse practitioner, and other licensed providers working under the supervision of the PCP. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical or behavioral services to the patient.