Phoenix 2 Operations
2602 S 47th Street
Phoenix, AZ 85034

MEDICAL NECESSITY (CMN) FORM FOR TRANSPORTATION ATTENDANTS

(Providers are required to complete this form for members 18 and older requesting an attendant that is 18 and older.)

FAX: (866) 402-0522
PHONE: (866) 400-8233
TTY: (866) 288-3133

MEMBER INFORMATION			MEDICAL PROVIDER INFORMATION		
Date of Birth: / /	Sex: M F	Age:	Member ID	Medicaid #:	Phone #:
Patient/Member Name (Last, First, MI):			Medical Provider Name and Address:		
If attendant is medically necessary, please continue filling out form below.			**If attendant is NOT medically necessary, please fill out this box and return the form by fax to 866-402-0522.** **_____ Attendant is not medically necessary.*** **Date:** **Signature: _____** * Pursuant to NMAC Regulation 8.324.7 I., if the attendant is not medically necessary, the member will not be able to take an escort on the trip.		

LEVEL OF SERVICE REQUIRED BY MEMBER AND PRESCRIBED BY MEDICAL PROVIDER

Medically Necessary Attendant

Ambulatory + Personal Care Attendant O
Wheelchair + Personal Care Attendant O
Wheelchair Transport O
Width of Chair:

Medical Equipment Needed

__ Airway monitoring and/or suctioning
__ Oxygen
__ Ventilator-dependent
__ Other _____

Medical Necessity Criteria

__ Bed-confined
__ History of existing paralysis/CA
__ Decubitus ulcers/cannot sit safely
__ Hip/leg/back precautions
__ Contractures
__ Confused/lethargic/comatose
__ Cannot support self while seated in a wheelchair for transport distance
__ Other_____

Summarize 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 if necessary.)

_____
_____
_____

Estimated duration of level of service *(check one)*: O 90 Days O 180 Days O Other:

Such services are funded in part with the State of New Mexico.

This certification may be completed and signed only by the member's attending physician, physician assistant, or certified nurse practitioner to confirm a medically necessary level of service.

Knowingly providing false information on this certification may constitute fraud and may prevent the patient/member from receiving further transportation services. If you have any questions, please contact Modivcare's Facility Assistance Department at **866-400-8233.**

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 patient's/member's transport is medically necessary for the patient's/member's health.

NAME: _____ SIGNATURE: _____ DATE: _____

Fax completed form to: (866) 402-0522

Mail completed form to:
(If mailing, please allow
7-10 days for processing.)

Facility Department
2602 S. 47th Street, Suite 100
Phoenix, AZ 85034