REFERRAL REQUEST FOR TRANSPORTATION SERVICES AND PHYSICIAN CERTIFICATION STATEMENT (PCS)

The Department of Health Care Services (DHCS) requires that a PCS Form be used to process and determine the appropriate level of all Non-Emergency Medical Transportation (NEMT) services. ***Please submit completed, signed forms to:***

☐ **Routine: 714-338-3153** ☐ **Retrospective: 714-338-3153** ☐ **Urgent: 714-571-2424**

Incomplete or inaccurate forms may cause delays and/or denials.

Patient Information:

First Name: Last Name: Date of Birth:

Medi-Cal Number / CIN#:

☐ Home ☐ Board and Care ☐ ICF-DD ☐ SNF ☐ Other:

Prescribing Provider Information:

Provider's Full Name (Print):		Provider NPI:
Phone Number:		Fax Number:
Facility Name:		Fax Number:
Contact Name:		Contact Direct Phone Number:

NEMT – PRESCRIPTION, MEDICAL NECESSITY CRITERIA, PCS AND REQUIRED SIGNATURE

Disclaimer: CalOptima Health is required to authorize the lowest cost type of NEMT services that is appropriate for the member's medical needs. Once the PCS is submitted, CalOptima Health cannot modify the authorization to a lower level without a new PCS form from the provider.

NEMT Vehicle Type

☐ Ambulance ☐ Litter/Gurney Van ☐ Wheelchair Van ☐ Air Ambulance

NEMT Provider Name: Provider NPI:

Phone Number: Fax Number:

NEMT Anticipated Duration:

Start Date:	End Date:	☐ Six (6) Months	☐ 12 Months

Justification: Provide medical documentation of specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles. *Diagnosis alone does not constitute medical necessity* (state functional limitations):

Diagnosis: ICD-10 Code(s):

☐Condition contraindicates the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)

☐Member is incapable of sitting for the length of time needed to transport

☐Member must be transported by wheelchair and is unable to self-transfer or self-propel

Certification Statement: This form **must be signed** by the physician, physician assistant, nurse practitioner, certified nurse-midwife, physical therapist, speech therapist, occupational therapist, dentist, podiatrist, mental health or substance use disorder provider responsible for providing care to the member and responsible for determining medical necessity of transportation consistent with the scope of their practice.

Signature (Required):_____ **Date:**_____

I certify that California Code of Regulations [CCR], Title 22, Section 51323 (c) (2) was used to determine medical necessity for thetype of transportation requested.