



**To:** **From:** ModivCare - Transportation Dept.

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**Fax:** **Fax:** 1-866-569-1906

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**Phone:** **Phone:** 1-866-569-1902

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**Pages:** 2 (Including Cover sheet)

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## **Your Immediate Attention Is Requested**

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**Following this cover sheet is the PTR FORM (Physician's Transportation Restriction Form).**

The restrictions and requirements stated on this form will be used by ModivCare to determine the best means of transportation for the patient/member.

The PTR form should 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 of the patient's medical needs, capable of accurately completing the form, and is providing direct medical or behavioral services to the patient.

**Please be aware, if the form is not completed and returned, the member will receive the most appropriate means of transportation.**

Thank you for your anticipated cooperation,  
ModivCare (formerly Logisticare)

### **CONFIDENTIALITY STATEMENT**

This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed. It may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination or copying of this message or any attachment is strictly prohibited. If you have received this transmittal in error, please notify the original sender immediately by telephone or by return e-mail and delete this message, along with any attachments, from your computer.  
Thank you –ModivCare (formerly Logisticare)

## PHYSICIAN'S TRANSPORTATION RESTRICTION FORM

**The purpose of this form is for a physician to communicate to ModivCare (formerly LogistiCare) 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 (formerly LogistiCare) 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 ¼ 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 (formerly LogistiCare) pays for the aide's/companion's fare,  
(But ModivCare (formerly LogistiCare) 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:**

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### 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 (formerly LogistiCare) 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.
  - o Medical Reason(s): \_\_\_\_\_

### Physician Information:

NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

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.