LogistiCare

795 Woodlands Pkwy, Ste 300, Ridgeland MS 39157
866-333-1988 phone / **866-333-3357 fax**

Pre-Transportation Verification Form

This form must be filled out completely and returned by the date below.
Without this form we cannot approve transportation to this appointment.

Fax to: 866-333-3357

To:	Attn:
Phone:	Fax:
This Form MUST be Faxed back by NOON on:	in order for this patient to be transported to your office.
Today's Date:	This Certificate good ONLY for 3 months from this date.
Reason for Request:	Excessive Mileage
LogistiCare Employee requesting Certification: Alice Walker ext 216	Trip Date & #

Medicaid Member's Information:

Name:	Date of Birth:	Medicaid ID #:
Address:		Apartment:
City:	State:	Zip:

Medical provider to/from whom the member is to be transported:

Physician / Facility:		
City:	State:	MS Medicaid Provider #:

To be completed by the **Attending Medical Provider** or the **Referring Medical Provider** if the patient has not yet been seen by the provider to whom they are requesting to see (complete **ALL** items, in their entirety):

If the answer to any of these questions is **NO**, do not complete the remainder of this form as we will be unable to offer transportation assistance.

1	Does this patient have a condition that would prevent them from being treated by a nearer physician?	[ ] Yes	[ ] No
2	Are you the nearest physician able to treat the patient's condition under Medicaid coverage?	[ ] Yes	[ ] No
3	Will this appointment be covered by Mississippi Medicaid?	[ ] Yes	[ ] No
4	Are you billing Mississippi Medicaid for costs associated with this appointment?	[ ] Yes	[ ] No

Certifying Physician:

Signature of attending physician: _____ **Date:** _____

Printed name of attending physician: _____

MS Medicaid provider number of attending physician / facility: _____