



**PROVIDER CERTIFICATION OF MEDICAL NECESSITY (MNF) FORM
FOR TRANSPORTATION/MILEAGE REIMBURSEMENT FOR OVER
120 MILES**

**FAX to ModivCare: (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):			Referring Medical Provider Name and Address:		
Medical Provider Name and Address:			If transportation is NOT medically necessary, please fill out this box and return the form by fax to (866) 402-0522. _____Transportation is not medically necessary.* Date: _____ Signature: _____ * Pursuant to NMAC Regulation 8.310.2.12(L)(12)(b), if transportation is not medically necessary, the member will not be able to schedule the trip.		
If transportation is medically necessary, please continue filling out this form below.					
REQUIRED BY MEMBER AND APPROVED BY MEDICAL PROVIDER					
<u>Medically Necessary</u> ☐ 120 Miles					
Please provide justification of medical necessity for transportation for over 120 miles outside of the home community. 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): ☐ 12 Months ☐ Other:					

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