

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					
<u>Medically Necessary Attendant</u> Ambulatory + Personal Care Attendant ☐ Wheelchair Transport ☐ Wheelchair + Personal Care Attendant ☐ Width of Chair: _____					
<u>Medical Equipment Needed</u> ___ Airway monitoring and/or suctioning ___ Oxygen ___ Ventilator-dependent ___ Other _____			<u>Medical Necessity Criteria</u> ___ 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 (<i>check one</i>): ☐ 90 Days ☐ 180 Days ☐ 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