modivcare

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PHYSICIAN/OTHER LICENSED PROVIDER TRANSPORTATION ATTESTATION FORM

The purpose of this form is for a Physician/Licensed Clinician to communicate to LogistiCare specific transportation needs of a patient / member due to a medical or behavioral health condition. The criteria and requirements stated on this form will be used by LogistiCare to determine the safest and most appropriate way to provide transportation to the patient / member.

Patient / Member Information: Name: _____ DOB: __/__/____

Medicaid #/ ID #:_____ Member Telephone Number: _____

Member Address: _____

Transportation Needs: *(Please check all that applies; must be completed by the treating physician/licensed healthcare clinician)*

Can the patient use mass transit? Yes ☐ No ☐

(Note –All patients/members are required to use mass transit (bus) if both they and their provider are located within a ½ mile of a bus stop, able to walk ½ mile and can understand written signs.

If you checked No, please **check** the medically necessary mode of transportation you deem appropriate for this patient:

☐ **(a) Ambulatory (also called curb to curb):** The patient can get to the curb, board and exit the vehicle unassisted, or is a collapsible wheelchair user who can approach the vehicle and transfer into the vehicle without assistance

☐Yes, and must be accompanied by a companion

☐ (b) **Wheelchair:** The patient is a wheelchair user who requires lift-equipped or roll-up wheelchair vehicle **and** assistance (cannot transfer **with ease/safely**)

☐ **(c) Stretcher Van:** The patient is confined to a bed, cannot sit in a wheelchair, **and does not** require medical attention/monitoring during transport.

☐ (d) **BLS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient.

☐ (e) **ALS Ambulance:** The patient is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring, and tracheotomy.

If you selected letter **(a-e)** above, please use the following space to justify the corresponding mode of transportation by a brief description of the **functional limitation that results in the need for this form of transportation.**

Disclaimer: Please note LogistiCare is not responsible for surmounting any home barriers that the member may have; however, we are able to refer the member to the relevant department and/or organization that can help them to surmount these barriers as long as we are made aware of their situation when transportation is requested.

Estimated Duration of This Level of Service. (Check One) 30 **Days☐ ;60 Days☐;**

90 Days ☐; 120 Days ☐; other ☐ (will be reviewed every 6 Mot); Permanent ☐

I have evaluated this patient/member and certify that the information provided above is accurate and may be used to determine the best means of transportation for the patient/member.

Name (Print): _____ RI DOH License #:

Signature: _____ Date: __/__/____

Must be signed by the treating Physician/Licensed Healthcare Clinician

Physician Practice/Facility Name: _____ Telephone _____

Address:

Knowingly providing false information on this Certification may constitute fraud and may result in sanctions against provider. If you have any questions, please contact LogistiCare's Utilization Review Department at ***855-330-9129.***

Note: If the patient requires an escort, the escort will be transported at no additional charge from the patient's home or other point of departure. LogistiCare must be informed at least 24 hours in advance, to ensure adequate seating in vehicle (no form required for minor child escort).