Certification of Medical Necessity for Non-Emergency Stretcher Transportation

MEDICAID MEMBER INFORMATION

Name: ____Trip Date_____________________________

Medicaid Number: ________________________ Date of Birth: ____________________Age: ________

Nature of Appointment: ____

Preferred Transportation Provider: ____

The following criteria must be met and applicable to the condition of the member at the time stretcher services are provided (circle all that apply):

1. The Member is unable to get up from bed without assistance
2. The Member is unable to ambulate; and
3. The Member is unable to sit in a chair or wheelchair

Please describe the member's physical condition(s) that makes transportation by stretcher medically necessary (i.e. normal transportation would endanger the health of the Member) and describe the Member's general physical condition:_____________________________________

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RN Signature (single trip only)____

If member's condition is persistent, a physician may request certification for up to 90 days.

Explanation: ____

Physician's Name (print): ____

Physician's phone no.: (_____) _______-__________________

Medicaid Provider Number: _______________________________

I certify that the above information represents an accurate assessment of the member's medical condition(s). In addition it is my professional medical opinion that this member requires transport by stretcher and should not be transported by any other means.

Physician's Signature: ____ Date: ___________

PLEASE RETURN VIA FAX TO

877-601-0530

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