modivcare

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

LEVEL OF SERVICE CERTIFICATION OF MEDICAL NECESSITY

Required for All Patients / Members Using Wheelchair or Stretcher Transport

FAX # 877-813-5599 | PHONE # 866-469-2824

Patient / Member Name:		Medical Provider Name:	**Date:**
Patient / Member Address:		Medical Provider Address:	
Medicaid ID #	DOB:		
Phone #		Phone #	Fax #

Medical Necessity Criteria
(Please document all conditions that apply)

☐ Wheelchair ☐ Manual ☐ Electric ☐ Bariatric	☐ Stretcher ☐ ALS ☐ BLS ☐Bariatric
___Able to ambulate short distances – Needs WC for long distances ___Unable to safely transfer from wheelchair to ambulatory vehicle ___Unable to ambulate ___Able to sit upright ___Able to sit upright – Has self-administered Oxygen ___Able to sit upright – Requires continuous Oxygen	___Unable to stand and pivot from prone position to wheelchair ___Unable to sit upright – Requires continuous Oxygen ___Unable to sit upright – Does not require medical monitoring ___Unable to sit upright – Requires medical monitoring

Weight:	**Height:**	**Stairs (Interior/Exterior):**

Summary of patient's / Member's medical condition establishing the medical necessity for the prescribed level of service:

I certify that the above information is true, accurate and complete based on my evaluation of this patient / Member and represent that due to the patient's / Member's condition he/she requires transport by the mode requested on this form. I understand that this information will be used by Modivcare and the Department of Medicaid and Medical Assistance (DMMA) to support the determination of medical necessity for services provided, and that I have personal knowledge of the patient's / Member's medical condition at the time of transport.

TITLE: **DATE:**

This Certification may be completed and signed only by the patient's / Member's attending physician, physician's assistant, or Registered Nurse to confirm a medically necessary level of service.

Submitter's Contact Information

Name:	Email:
Phone Number:	