



INCOMPLETE FORMS WILL NOT BE PROCESSED

PHILADELPHIA MATP

PHYSICIAN'S TRANSPORTATION RESTRICTION FORM

The purpose of this form is for physicians to communicate to ModivCare specific transportation restrictions of patients **due to a medical condition**. The restrictions and requirements declared by physicians using this form will be used by ModivCare to determine the best means of transportation for the patient. ModivCare will verify the information provided on this form and report discrepancies to the Department of Human Services.

THIS FORM MUST BE COMPLETED IN FULL OR IT WILL NOT BE PROCESSED RESULTING IN A DELAY IN TRANSPORTATION SERVICES.

Today's date: _____ Patient's Name: _____
Patient's Medicaid ID Number: _____ Patient's DOB: ____/____/____

To be completed by the treating Physician (**Please Print**):

Transportation Needs: (Please answer all)

- 1. Patient is medically unable to use public transportation. Yes No
- 2. Patient is medically unable to walk 1/4 mile. Yes No
- 3. Patient is medically able to use public transportation ONLY if accompanied by a companion.
(In such case ModivCare will pay for companion fare.) Yes No
- 4. Patient requires an escort. Yes No
Please indicate Medical Reason for escort (required) _____
- 5. Patient requires low riding vehicle. Yes No
Please indicate Medical Reason for low riding vehicle (required) _____
- 6. Patient needs wheelchair vehicle. Yes No
- 7. Does this patient travel by public transportation for other purposes such as shopping, etc.? Yes No

8. List the medical condition which requires specified transportation needs above (**Please Print Clearly**):
*****This form will not be accepted without a medical reason for the need for paratransit services.*****

9. **Mode of Transportation required based on the patient's medical necessity** (please check only one):
 Mass Transit Paratransit Wheelchair Van (wheelchair certification form also required)

10. **Period of Incapacity:** **Permanent?** Yes No 6 months.

If **no**, expected Expiration date of Restrictions: _____

Physician's Name (print): _____

Physician's phone no.: (____) _____ - _____

Physician's Signature: X _____ Date: _____

I certify that the information provided for this member represents a true evaluation of the member's medical condition. I understand that this form is utilized by ModivCare to determine the appropriate mode of transportation for the member based on their medical condition. Any discrepancies reported in the information provided can be misrepresentation of MATP fund which constitutes Medicaid fraud.

Please return this form via fax to ModivCare, Philadelphia:
Attn: Exception Department
Phone: 1-877-835-7426
Fax: 1-877-835-7432