modivcare

Return Completed Form to:
Email: HIExceptions@modivcare.com
Fax: (866) 475-5745

MEDICAL NECESSITY FORM

The purpose of this form is for a medical care provider* to communicate to ModivCare Solutions, LLC ("Modivcare") specific non-emergency medical transportation (NEMT) requirements for members due to a medical condition. The restrictions and requirements declared by a medical care provider* using this form will be used by Modivcare, within the realm of the anticipated NEMT broker services being provided to Hawaii Medical Service Association (HMSA)'s Members, to determine the appropriate means of transportation for the Member.

Date: _____

Member Information

Name: _____

Address: _____

Phone Number: _____

Medicaid ID Number: _____

Date of Birth: _____

Transportation Needs: Please check all that apply; must be completed by a medical care provider* only.

☐ This Medicaid billable program/appointment is medically necessary. This is the nearest appropriate Medicaid provider.

☐ Member is medically unable to walk ¼ (one-fourth) of a mile.

☐ Member is NOT able to be driven by a friend or family member.

☐ Member is medically able to use public transportation ONLY if accompanied by a companion. (*In such case, Modivcare will pay for companion's fare but will not provide an aide or companion for the Member to utilize.*)

☐ Member is Paratransit certified.

☐ Member can only be transported by stretcher and does not need immediate medical attention during transportation.

Medical Reason(s): _____

☐ Does Member have a wheelchair? Type: ☐ Manual ☐ Electric ☐ Scooter (please check one)
(Modivcare does not provide wheelchairs.)

***Is member able to transfer WITHOUT assistance?** ☐ Yes ☐ No (please check one)

Return Completed Form to:
Email: HIExceptions@modivcare.com
Fax: (866) 475-5745

☐ Member is able to sit up on his/her/their own.

☐ Member uses a cane/walker. How many feet can Member walk using this equipment?

_____

☐ Member is medically NOT able to use public transportation

****Describe the specific medical conditions directly related to the need for a higher level of service other than public transportation**: _____

Is period of incapacity permanent? ☐ Yes ☐ No

If No, expected expiration date of restrictions:

_____

☐ Member needs one personal assistant/escort throughout duration of all transports. **All Members under age 18 need an adult escort.**

Indicate the anticipated length of time the Member will require this level of service:

__/__/____

Medical Care Provider Information (Please ensure form is accurate and complete prior to signing)

I _____, the medical care provider (*such as: physician, physician assistant, or nurse practitioner), have evaluated this member and certify that he or she is medically/functionally appropriate for the mode of transportation designated above.

I hereby certify that all information provided by me in connection with this application, including any documents, attestations, or representations submitted, is true, complete, and accurate to the best of my knowledge. I understand and acknowledge that I am solely responsible for the authenticity and accuracy of all such information.

NAME (printed): _____

TELEPHONE: _____

SIGNATURE OF MEDICAL CARE PROVIDER: _____

DATE: _____

****Per the Hawaii Revised Statutes HRS §489E-7, this electronic signature satisfies the law.*