A health plan offered by WellCare Health Insurance of Arizona, Inc.

Certification of Medical Necessity of Mode of Transportation
Medicaid-covered services
(Fax to: 1-866-790-8808)

Instructions: Type or print clearly. All areas of this form must be completed and signed by a medical care provider to verify the mode of transportation required for the member. Only a *physician, physician assistant, nurse midwife, nurse practitioner or service coordinator* may be an evaluator and sign this form.

1. Patient/Member Information:	**2. Insurance Information:**
Name: ______________________________	'Ohana Plan ID #: ______________________________
Address: ______________________________	Medicaid ID #: ______________________________
Date of Birth: ______________________________	PCP Name: ______________________________
Phone: ______________________________	Phone: ______________ Fax: ______________

Provider please answer the questions regarding member's needs:

3. Mode of transportation required for Medically Necessary Medical Appointments:

*3(a).*The patient is ambulatory:

☐ Yes

☐ No (A patient is ***not*** ambulatory if they have a permanent or temporary disabling condition, which precludes transportation in a motor vehicle or motor carrier that has not been modified or created for transporting a person with a disabling condition) – why: ______________________________

*3(b).*The patient has free transportation available (check all that are available to patient):

☐ Patient owns vehicle ☐ Facility resident service

☐ Family/friends/volunteers ☐ Other ____________________

*3(c).*The patient can ride public bus transportation:

☐ Yes

☐ Yes – the member has a wheelchair and can ride public bus transportation

☐ No – due to the following explanation: ______________________________

____

If YES, go to step *3(i).*

*3(d).*The patient can ride curb-to-curb Handi-Van transportation:

☐ Yes

☐ Yes – the member has a wheelchair and can ride Handi-Van transportation

☐ No – due to the following explanation: ______________________________

____

If YES, go to step *3(i).*

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*3(e).*The options in above questions 3(b), 3(c), 3(d) have been explored:

☐ Yes

☐ No – why: ____

3(f). Does the patient medically need:

☐ Curb to curb with physical assistance in boarding a vehicle

☐ Assisted service (door to door and/or facility to facility)

3(g). Medical reason and determination for medically necessary higher level of alternate mode of transportation: ____

____

____

____

____

*3(h).*The non-ambulatory patient medically needs:

☐ Wheelchair (patient is able to be safely transported in a wheelchair) or

☐ Non-emergency stretcher service

3(i). If member is under 18, one escort will be provided. The patient medically needs an additional escort:

☐ Yes – why: ____

☐ No

*3(j).*If member is 18 or older, does the patient medically need an escort:

☐ Yes – why: ____

☐ No

I, ______________________________, the medical provider *(physician, physician assistant, nurse midwife, nurse practitioner or service coordinator),* have evaluated this member and certify that he or she has the medical limitations described above and therefore requires the mode of transportation designated.

Certifying Medical Provider Information:			
Medical Provider Name: (Last, First, Middle)	‘Ohana Provider ID#:	Phone Number:	Fax Number:
Medical Provider Signature:	Contact Person at Office:		Today’s Date: