

## 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.

### 1. Member Information:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### 2. Insurance Information:

‘Ohana Plan ID #: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

PCP Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### 3. Certification:

- The member does not have transportation available through self, family, friends, volunteers or others  
 The member cannot ride public bus transportation

### 4. Mode of transportation required for Medically Necessary Medical Appointments – check the most cost effective mode of transportation that member can safely take:

- The member can ride curb to curb Handi-Van service (Handi-Van evaluation and approval required)\*

\*TheHandi-Van: Member can call 1-808-538-0033 for more information or to schedule an in-person interview.

- The member requires curb-to-curb taxi service, provide explanation below:  
 Medical Issue  Functional Issue  Cognitive Issue  Mobility Issue  Other  
Explain: \_\_\_\_\_

- The member requires door-to-door taxi service, provide explanation below:  
Medical and/or Functional issue that necessitates door-to-door taxi Service:  
 Medical Issue  Functional Issue  Cognitive Issue  Mobility Issue  Other  
Explain: \_\_\_\_\_

### 5. Special Considerations – Check all that apply

- The member needs one personal assistant/escort throughout duration of transport (all members under age 18 need escort)  
 The member needs two personal assistants/escorts throughout duration of transport  
 The member uses a wheelchair for transport when outside a vehicle  
 The member uses a walker when ambulating  
 The member must be provided non-emergency stretcher service during transport  
 The member has an elevator  
 Additional passengers are problematic, no multi-loading

I, \_\_\_\_\_, the medical provider  
(\*such as: physician, physician assistant, nurse practitioner or service coordinator), have evaluated this member and certify that he or she is medically/functionally appropriate for the mode of transportation designated in **Section 4 above**.

### Certifying Medical Provider Information:

Medical Provider Name: \_\_\_\_\_ ‘Ohana  
(Last, First, Middle) \_\_\_\_\_ Provider ID#: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Contact Person at Office/Phone Number: \_\_\_\_\_

Medical Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_