Anthem BlueCross

Medi-Cal Managed Care
L.A. Care

Physician Certification Statement — Transportation Justification Request

This form provides LogistiCare or another authorized transportation provider with information about the appropriate level of nonmedical transportation (NMT) or nonemergency medical transportation (NEMT) needed for the member. Please return the completed form by fax to LogistiCare at **1-877-457-3352**, Attn: Utilization Review.

Patient name (Print clearly.): _____

Member ID number: _____ DOB: _____

Please check only **one** medically necessary mode of NMT. **Note:** A physician's signature **is not** required for NMT.

1. **NMT** includes transportation for medically necessary appointments and may be provided via taxi, sedan, paratransit (such as access) or fixed route transportation (such as a bus).
   - ☐ **Mass transit**: Patient/member is able to use public transportation and medically able to walk up to three-quarters of a mile to a bus stop (curb to curb).
   - ☐ **Paratransit services**: Patient/member (already certified, qualified or eligible to apply) can walk to the curb and board and exit a vehicle unassisted but cannot utilize the bus or train (curb to curb).
   - ☐ **Ambulatory (sedan, taxi)**: Patient/member can walk to the curb and board and exit the vehicle unassisted but cannot utilize the bus or train (curb to curb).
   - ☐ **Ambulatory door to door (sedan)**: Patient/member can walk but requires driver assistance from their residence to the medical appointment (door to door).
     - ☐ Wheelchair (able to transfer from a folding position without assistance)
       Note: If assistance is needed, please choose the wheelchair van option under NEMT instead.
       □ Walker □ Cane □ Crutches

Please check only **one** medically necessary mode of NEMT. **Note:** A physician's signature **is** required for NEMT.

NEMT includes ambulances, wheelchair vans and gurney vans and is provided when medically necessary and the patient is not ambulatory. NEMT transportation under Medi-Cal Managed Care is covered only when the patient's medical and physical condition does not allow him or her to travel by bus, passenger car, taxi or another form of public/private vehicle.

- ☐ **Wheelchair van**: Patient/member uses a power or electric wheelchair and requires a lift-equipped vehicle and driver assistance.
- ☐ **Stretcher/gurney van**: Patient/member is confined to bed, cannot sit in a wheelchair and does not require medical attention/monitoring during transport.
- ☐ **Basic life support ambulance**: Patient/member is confined to bed; cannot sit in a wheelchair; and requires medical attention/monitoring during transport for reasons such as isolation precautions, nonself-administered oxygen or sedation.
- ☐ **Advanced life support ambulance**: Patient/member is confined to bed; cannot sit in a wheelchair; needs advanced life support; and requires medical attention/monitoring during transport for reasons such as intravenous device monitoring, cardiac monitoring or tracheotomy.
- ☐ **Air transport**: Patient/member's medical condition is such that transport by ordinary means of private or public ground transportation is medically contraindicated.

2. Please justify the mode of transportation chosen above with a medical purpose specific to visit(s), including functional limitations that preclude the patient's ability to ambulate without assistance or be transported by private/public vehicle:

3. Duration of services (based on continued eligibility): □ 30 days □ 60 days □ 90 days □ 12 months

Certification statement: The physician, dentist or podiatrist responsible for providing care for the member is responsible for determining medical necessity for transportation. This certificate can be completed and signed by a participating physician group, independent practice association, PCP, MD, LVN, RN, PA, NP or discharge planner who is employed or supervised by the hospital, facility or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate. A completed and approved physician certification statement form may not be modified.

Staff/Physician's Name: _____

Staff/Physician's Signature: _____ Date: _____

Title: _____ Contact Phone: _____

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