Maintain Original in Medical Record

Form 2015 (3/2014)

MEDICAID TRANSPORTATION JUSTIFICATION REQUEST

New York State Department of Health

Patient Name _____ Date of Birth /___/____ Medicaid Number: _____

Address: _____ Telephone: _____

Please justify the mode of transportation by entering specific diagnosis and condition affecting the Enrollees ability to use Mass Transit

1. Please check the medically necessary mode of transportation only if the enrollee is unable to use the bus or subway:

Livery: The Enrollee can walk to the curb and board and exit the vehicle unassisted, but cannot utilize the bus or subway. Collapsible W/C enrollees who can approach the vehicle and transfer without assistance.

☐ **Ambulette Ambulatory:** The Enrollee can walk but requires driver assistance from residence to the medical appointment.

☐ **Ambulette Wheelchair:** The Enrollee is a wheelchair user, requires a lift-equipped or roll-up wheelchair vehicle and driver assistance.

☐ **Stretcher Van:** The Enrollee is confined to bed, cannot sit in a wheelchair, and does not require medical attention/monitoring during transport.

☐ **BLS Ambulance:** The Enrollee is confined to bed, cannot sit in a wheelchair, and requires medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient.

☐ **ALS Ambulance:** The Enrollee is confined to bed, cannot sit in a wheelchair, and requires medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring, and tracheotomy.

2. Please **justify the mode** of transportation chosen above by entering specific medical diagnosis and condition affecting the Enrollees ability to use Mass Transit:

3. Is the requested mode of transport **a long term** need of the patient, or **temporary**? Long Term ☐ Temporary ☐ If temporary, for how long?_____months

CERTIFICATION STATEMENT: I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.

_____ Physician's Name (PRINT)

_____ NPI#

___/___/____ Date

(____) _____-- _____. Telephone #

_____ Hospital/Clinic/Practitioner Name

_____ Hospital/Clinic/Practitioner Address

_____ Name of person who completed this form

_____ Title

(____) _____-- _____ Telephone #

Signature of physician completing form
Must be signed by MD., PA or NP

Fax to: 877-585-8758 (Brooklyn); 877-585-8759 (Queens); 877-585-8760 (Manhattan); 877-585-8779 (Bronx); 877-585-8780 (Staten Island)

Form must be completed in its entirety or it will not be processed or approved

Directions for properly completing Form 2015

The Medicaid Transportation Justification Request should only be used to request transportation for Medicaid Enrollees whose medical condition prevents them from using the NYC Mass Transit system. If during the course of their everyday activities the Enrollee uses either the Bus or Subway, this form should not be used to request transportation for any other mode of service.

The Modes of Transportation that can be requested using this form are:

Livery: The Enrollee can walk to the curb and board and exit the vehicle without assistance, but cannot utilize the bus or subway. Enrollees who use a collapsible W/C and can approach the vehicle transferring in and out of the vehicle without assistance.

Ambulette Ambulatory: The Enrollee can walk but requires driver assistance from his/her residence to the medical appointment.

Ambulette Wheelchair: The Enrollee is a wheelchair user and requires a lift-equipped or roll-up wheelchair vehicle and driver assistance.

Stretcher Van: The Enrollee is confined to bed, cannot sit in a wheelchair, but does not require medical attention/monitoring during transport.

BLS Ambulance: The Enrollee is confined to bed, cannot sit in a wheelchair, and requires medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient.

ALS Ambulance: The Enrollee is confined to bed, cannot sit in a wheelchair, and requires medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring, and tracheotomy.

Requests for all of the above listed Modes of Transportation must be justified by entering a specific medical diagnosis and a description of the Enrollee's medical condition that prevents the Enrollee from using the Mass Transit system.

Examples:

Acceptable Medical diagnoses: Developmental delays, CVA affecting any extremities, DJD/Herniated disc radiating to lower extremities
Unacceptable Medical diagnoses: Needs assistance, weak, Car service, Medical condition prevents use of public transportation, Bipolar

This form must be completed in its entirety in order for the form to be processed and approved. Any omissions will result in the form being denied as incomplete. Incomplete forms will be returned and will require the facility to resubmit the request which may result in the Enrollee receiving the inappropriate mode of transportation.

All forms must be signed by a Medical Doctor, Physician's Assistant or a Nurse Practitioner.

Only submit Form 2015 to LogistiCare, this direction page does not need to be sent.