MassHealth
Commonwealth of Massachusetts · EOHHS
www.mass.gov/masshealth

Return completed form to: MassHealth Transportation Unit, P.O. Box 45, Boston, MA 02112-0045, or fax it to 617-988-2925.

PRESCRIPTION FOR TRANSPORTATION FORM

Please indicate the type of request: ☐ New form ☐ Renewal ☐ Increase in visits ☐ Alternate pick-up address

Please print or type all information.

1. MassHealth Member Information

Last name | First name | Date of birth

Member ID | | | | | | | | | | | | | Tel. no.

HOME ADDRESS (The MassHealth member will be transported to and from this address, unless an alternate pick-up address is listed.)

Street address | Apt. no. | City/Town | State | Zip

ALTERNATE PICK-UP ADDRESS

Street address | Apt. no. | City/Town | State | Zip

MAILING ADDRESS (if different from home address)

Street address | Apt. no. | City/Town | State | Zip

2. MassHealth Provider Information (Section to be completed by the provider requesting transportation.)

Name of treating provider/facility | Tel. no. | Ext.

Street address | Suite no. | City/Town | State | Zip

MassHealth provider ID/service location | | | | | | | | | | | NPI | | | | | | | | | |

3. Name and Location of Treating Provider/Facility (Indicate where the MassHealth member will be seen.) Check if same as provider listed in Section 2. ☐

Name of treating provider/facility | Tel. no. | Ext.

Street address | City/Town | State | Zip

MassHealth provider ID/service location | | | | | | | | | | | NPI | | | | | | | | | |

Is the treating facility within the member's locality (city or town of residence, or adjacent city or town)? ☐ Yes ☐ No

If No, please justify:

4. Medical Treatment Type

Please list the MassHealth-covered service(s) that the member is receiving at this location.

5. Duration and Frequency of Treatment

How long will the MassHealth member require these services? ___ week(s) ___ month(s)

How frequently will the MassHealth member be seen for this service? ___ visit(s) per week ___ visit(s) per month

6. Why Transportation Services Are Required

Is there a medical reason why the member (or guardian if accompanying a minor) is unable to use public transportation? ☐ Yes ☐ No

If Yes, please describe specific medical reason:

7. Other Information

Is a wheelchair van needed? ☐ Yes ☐ No

Is an escort accompanying the member for assistance with ambulation or to accompany a minor? ☐ Yes ☐ No

Specify other transportation needs:

8. Provider/Dental TPA Signature

Signature: | Date:

Please check applicable title: ☐ MD ☐ DDS ☐ RNP ☐ RNC ☐ Other (Specify title)

Do not write below this line · MassHealth use only

☐ APPROVED. Authorization expires on: | Tracking no.:

☐ DENIED. Reason:

MassHealth authorized signature: | Date:

Instructions for Completing the Prescription for Transportation Form

Section 1 – Enter the member's name, date of birth, MassHealth member ID, telephone number, and home address, including apartment number, if applicable.

In certain circumstances MassHealth may authorize a member to be picked up at an address other than his/her home address. If the member is to be picked up at an alternate address, enter the alternate address information below the home address information. If there is a mailing address that is different from the home address, enter that below the alternate pick-up address.

Section 2 – Enter the provider's name, telephone number, address, MassHealth provider ID/Service location, and the NPI.

The provider requesting transportation must be a physician, physician's assistant, nurse midwife, dentist, nurse practitioner, psychologist, or managed-care representative, and an active MassHealth provider.

Section 3 – If the provider is also the treating provider, place a checkmark in the box labeled "Check if same as provider listed in Section 2." If the treating provider is different from the provider filling out Section 2, enter that provider's name, telephone number, address and, if known, their MassHealth provider ID Service location, and the NPI.

If the treatment destination is outside of the member's locality (city or town of residence, or immediately adjacent communities), indicate why the medical care is unavailable to the member within the member's locality.

Section 4 – Describe the specific medical care that will be provided.

Section 5 – Indicate how many weeks or months the member will require transportation, and how frequently the member will be going per week or per month for the service. MassHealth will not authorize more than six months of transportation for an acute illness, or one year of transportation for a chronic illness. For a single visit, enter "1" week, and "1" visit per week.

Section 6 – Indicate if there is a medical reason that the member (or guardian, in accompanying the member) is unable to use public transportation. Provide the specific physical or mental disability that prevents the member from using public transportation.

Section 7 – Indicate if a wheelchair van or an escort is necessary.

Wheelchair van transportation may be provided for nonemergency medical services for members who use a wheelchair or whose severe mobility impairments prevent them from traveling in a vehicle other than a wheelchair van.

Section 8 – The signature of the physician, dental third-party administrator, physician's assistant, nurse midwife, dentist, nurse practitioner, psychologist, or managed-care representative is required to process the PT-1 form. The signature certifies that the information contained on the form and any attachments, including medical necessity information (per 130 CMR 450.204) is true, accurate, and complete to the best of the signatory's knowledge. Any falsification, omission, or concealment of any material fact contained on this form may result in civil penalties or criminal prosecution.

For more detailed information about the MassHealth transportation benefit, consult the MassHealth transportation regulations at 130 CMR 407.000. If you have any questions about completing this form, please call the MassHealth Transportation Authorization Unit at MassHealth Customer Service at 1-800-841-2900.