New Jersey Non-Emergency Transportation Services Medical Necessity Form

Physician or Medical Professional (RN, PA, NP)

Phone: 866.527.9945 ext. Fax: 877.457.3316

The purpose of this form is for physicians to communicate to Logisticare specific transportation restrictions of patients **due to a medical condition.** The restrictions and requirements declared by physicians using this form will be used by LogistiCare to arrange the best means of transportation for the patient as defined by the health plan. THEREFORE THE STATEMENTS MADE BY PHYSICIANS REGARDING PATIENT TRANSPORTATION RESTRICTIONS ARE MADE UNDER PENALTY OF MEDICAID FRAUD.

Today's date: ________________ Patient's Name: ____ _

Patient's Medicaid ID Number: ___________________________________Patient's *D.O.B.:* _________ *I* __ -,*I* ____ _

Preferred Transportation Provider: ____----._

To be Completed By Physician or Medical Professional ***(Please Print where applicable):***

Transportation Needs: **(Please check the one that applies)**

Patient is medically/mentally able to use public transportation Yes ( ) No ( )

If the answer is no, what Level of Service does the patient travel:

Ambulatory (curb to curb) ( )
Ambulatory/MAV (Door through Door) (
Wheelchair/MAV ( )
BLS (Patient is bed bound) ( )

Diagnoses: (No CPT Codes): ______________________________________ _

If patient is unable to use public transportation, please describe the medical condition that requires Ambulatory or a higher form of transportation:

Physician's Name (print): ______ _______________________________ _

Physician's phone no.: (______)________________________________ _

Physician's fax no: ( )____ ________________________________ _

Please make sure form is filled out accurately and completely before signing.

Physician's Signature: X Date: ____________ _

LogistiCare Medical Director Signature: X Date: _____________________ _

Please return form by facsimile to 877-457·3316

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