# Closest Provider Certification

This form must be completed by a healthcare provider to verify any trip outside of the member's local community—over 10 miles in urban areas and 20 miles in rural areas—is medically needed. For more information on rural areas, please visit: http://www.ruralhealthct.org/towns.htm

## MEMBER INFORMATION

| First Name | Last Name |
|---|---|
| Medicaid ID Number | Date of Birth (MM/DD/YYYY) |

## HEALTHCARE FACILITY INFORMATON NOTE: Must Be a Participating Medicaid Provider

| Healthcare Provider's Name | Facility Name | | |
|---|---|---|---|
| Type of Facility ☐ Behavior Health ☐ Medical ☐ Dental ☐ Clinic ☐ FQHC ☐ Other_____ | Phone Number | | |
| Facility Address | City | State | Zip Code |

## MEDICAL REASON

Please specify the medical reason for the member needing to travel beyond 10 miles (urban) / 20 miles (rural) for care:

- ☐ Services are not available closer to the member's home
- ☐ Closest provider available for critical care/advanced treatment/medical services
- ☐ Closest provider available for urgent treatment
- ☐ Engaged in additional level of care at facility
- ☐ Current ongoing course of treatment requiring continuity of care
- ☐ Other, please explain: _____

## SUPPORTING INFORMATION

Please include any additional supporting information that would help Veyo understand the member's medical circumstance / needs.

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

X

Provider Signature _____ Date _____

**Please submit completed forms by email, mail, or fax:**

**Email:** ctcc@veyo.com

**Fax:** 860-724-2159

**Mail:** Veyo
Attn: Clinical Coordinator
PO Box 1070
Windsor, CT 06095