Companion Request Form

This form is to be completed by a healthcare provider to communicate to Veyo when a HUSKY Health member needs to travel with an attendant or escort due to a **physical, mental or intellectual medical condition** that prevents the member from traveling alone safely.

MEMBER INFORMATION	
First Name	Last Name
Medicaid ID Number	Date of Birth (MM/DD/YYYY)

COMPANION MEDICAL NECESSITY

☐ Member is medically **able** to travel without a companion

☐ Member is medically **unable** to travel without a companion (if selected, please complete questions 1-2 below)

1. Please describe the member's medical condition/s that requires the assistance of a companion?

2. Does this member need a companion for all medical appointments, or just for specific visits (such as dialysis)?

HEALTHCARE PROVIDER INFORMATION	
First Name	Last Name
Facility Name	Phone Number

- **Please make sure all information is accurate and complete before signing**
- **Companion Referral Forms expire twelve (12) months from signature date**

By signing this form, I acknowledge that any statements made above regarding the member/companion medical necessity are true and accurate, under the penalty of **Medicaid Fraud**.

X ______________________________ ______________

Provider's 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