

Specialized Transportation Form



This form needs to be completed by the hospital/discharging facility that is determining the medical necessity of the transport / requested level of service.

PATIENT INFORMATION																							
<p>Please check the below boxes that apply to the requested transport type:</p> <p><input type="checkbox"/> Out of State <input type="checkbox"/> In State <input type="checkbox"/> Border Hospital / Provider <input type="checkbox"/> Higher Level of Service than Public Transportation</p>																							
Member Name:		Medicaid ID Number:																					
Date of Birth (MM/DD/YYYY):	Age:	Valid Phone Number:																					
Pick Up Address:		Drop Off Address:																					
Trip Date:	Trip Time (if known):	Trip Detail: <input type="checkbox"/> One Way <input type="checkbox"/> Round Trip																					
<p>Transportation Needs (Please check ALL that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Patient CANNOT use public transportation due to a medical condition <input type="checkbox"/> Patient is medically UNABLE to walk 4 blocks <input type="checkbox"/> Patient is medically UNABLE to be driven by friend / family <input type="checkbox"/> Patient is medically ABLE to use public transportation <input type="checkbox"/> Patient requires a Wheelchair Vehicle <input type="checkbox"/> Patient requires a Stretcher Vehicle <input type="checkbox"/> Patient requires a Sedan (livery) Vehicle <input type="checkbox"/> Patient needs companion for teaching / participation in medical care <input type="checkbox"/> No multi-loading / immunosuppressed <input type="checkbox"/> Other multi-loading restrictions: _____ 		<p>Eligibility / Authorization Information:</p> <table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th style="text-align: center;">YES</th> <th style="text-align: center;">NO</th> </tr> </thead> <tbody> <tr> <td>Medicaid Covered Service</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Medically Necessary / Appropriate</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="3">Notification made to: (Name of ASO): _____</td> </tr> <tr> <td>The Service the Patient Requires Is Not Available in the Area</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>DSS Approval Required</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Patient Referred to Closest Available Provider for Condition</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Additional Information:</p>		YES	NO	Medicaid Covered Service	<input type="checkbox"/>	<input type="checkbox"/>	Medically Necessary / Appropriate	<input type="checkbox"/>	<input type="checkbox"/>	Notification made to: (Name of ASO): _____			The Service the Patient Requires Is Not Available in the Area	<input type="checkbox"/>	<input type="checkbox"/>	DSS Approval Required	<input type="checkbox"/>	<input type="checkbox"/>	Patient Referred to Closest Available Provider for Condition	<input type="checkbox"/>	<input type="checkbox"/>
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HOSPITAL / DISCHARGING FACILITY CONTACT INFORMATION		
Your Full Name:	Phone Number:	Pager Number:
Email Address:	Additional Information (if any) / Urgent Rationale:	PA#:

Specialized Transportation Form



RECEIVING PROVIDER OR FACILITY INFORMATION			
Facility Name:	Physician Name:	Date:	
Facility Address:	City:	State:	Zip Code
Physician or Facility Phone Number:	Appointment Reason:	Diagnosis Codes:	
Reason why authorization to transport member to specified provider is being requested (check ALL that apply): <input type="checkbox"/> Closest CMAP (Medicaid) Provider <input type="checkbox"/> Visit is Follow-Up After Surgery <input type="checkbox"/> Patient has established a Relationship with Provider	Anticipated Period of Incapacity from Today's Date: <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days		
(Please provide the type of Provider)	Additional Information (Include Height/Weight for WC/BLS/ALS transport):		
<input type="checkbox"/> Service Patient Requires is Not Available In Area <input type="checkbox"/> DSS Approved this Care <input type="checkbox"/> Provider is More Than 15 Miles from Member's Home Address			

TO BE COMPLETED BY VEYO			
Please check the level of service for requested trip: <input type="checkbox"/> Mileage Reimbursement <input type="checkbox"/> Public Transit <input type="checkbox"/> Paratransit <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> ALS <input type="checkbox"/> BLS			
Member Name:	Medicaid ID Number:	Trip Date:	
Pick-Up Time:	Drop-off Time (if round trip):	Trip Mileage:	
Cost of Trip:	Assigned NEMT Provider:	Provider Phone Number:	

X

 Health Care Provider Certifying Care Signature Print Name Legibly Date

DSS Review and Approval Contacts

- Roderick Winstead, roderick.windstead@ct.gov (Approval)
- Theresa Rugens, theresa.rugens@ct.gov (Reviewer)
- Srinivas Bangalore, srinivas.bangalore@ct.gov (Reviewer)

Veyo Clinical Coordinators

- Arrika Denbin, RN, BSN, adenbin@veyo.com
- Jaime Gallion, RN, BSN, jgallion@veyo.com
- Marie Jackson, RN, BSN, mjackson@veyo.com

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