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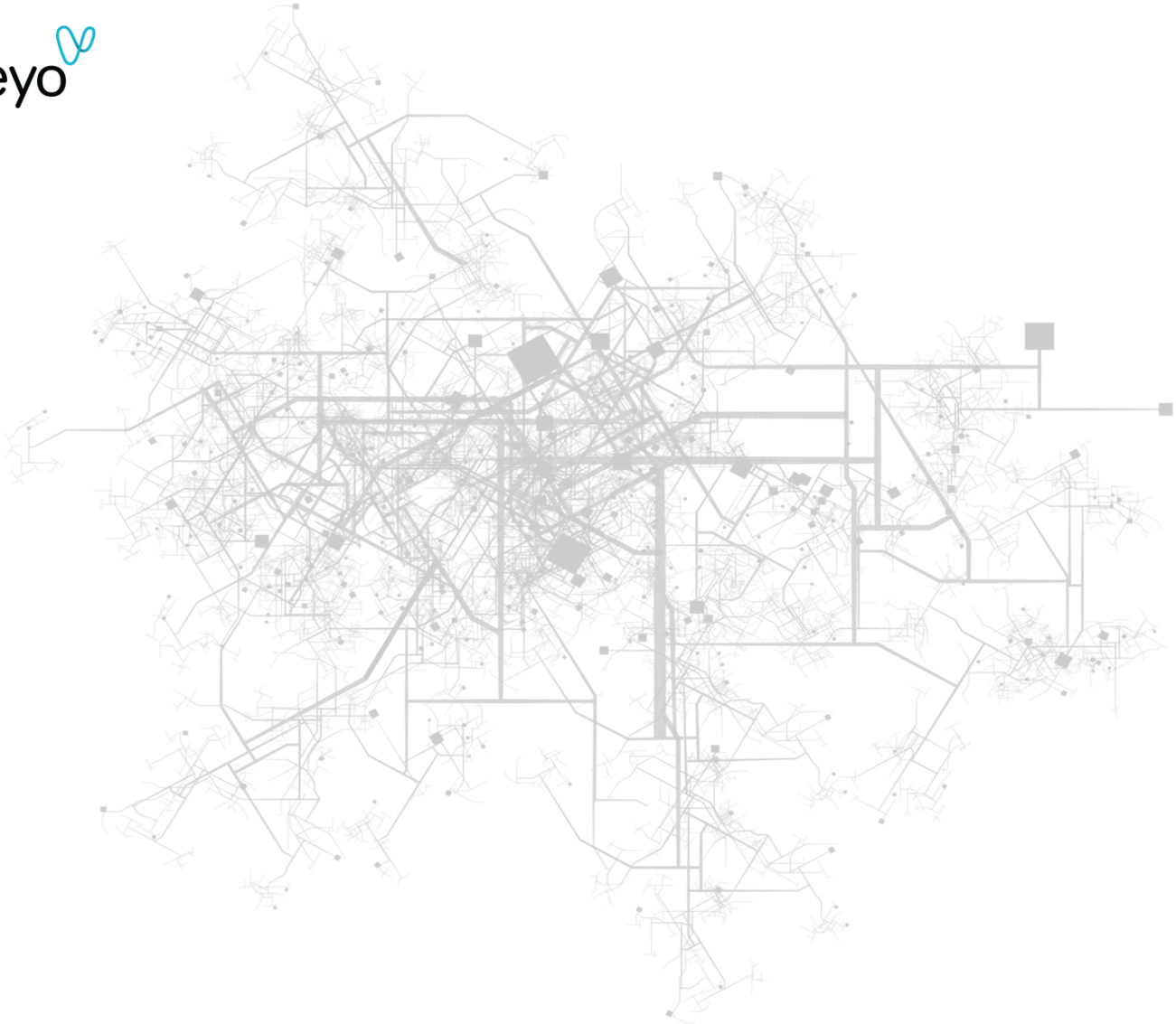


Specialized Transportation Form Guide

Tips on How to Use the New Form

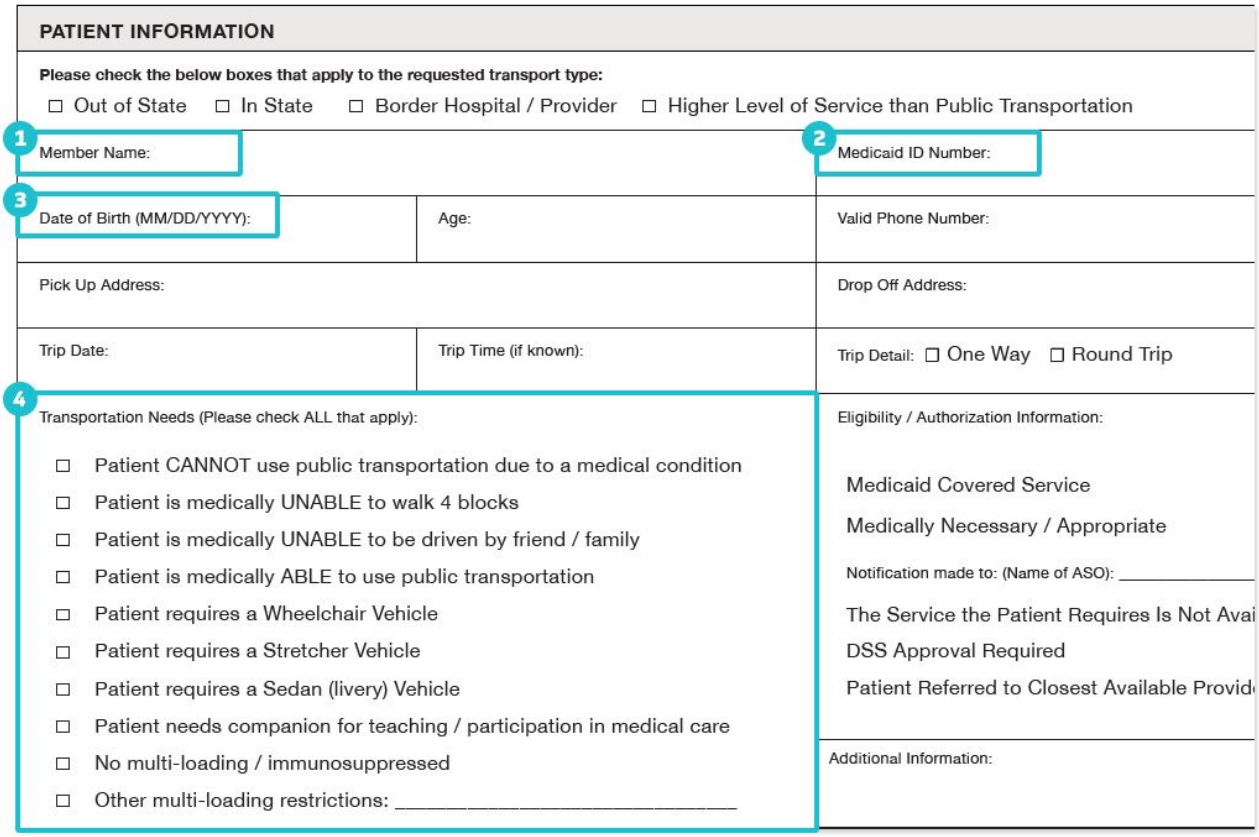
Volume 1.0 // August 17, 2018

Getting Started

The Specialized Transportation Form is going to be used as a one-stop shop for all Medical Override needs. If you need an alternate Mode of Medical transport, Need Closest Provider Certification or a Companion Override, please use this form as explained below.

How to Use the Form

For a **Medically Appropriate Mode Override** — please fill out, **1. Name**, **2. MID, 3.Date of Birth**, and **4. The Transportation Needs Section**, selecting which mode they need and the medical reason as to why they cannot use Mileage Reimbursement or Public Transportation for medical appointments.



PATIENT INFORMATION

Please check the below boxes that apply to the requested transport type:

☐ Out of State ☐ In State ☐ Border Hospital / Provider ☐ Higher Level of Service than Public Transportation

1 Member Name:

2 Medicaid ID Number:

3 Date of Birth (MM/DD/YYYY):

Age:

Valid Phone Number:

Pick Up Address:

Drop Off Address:

Trip Date:

Trip Time (if known):

Trip Detail: ☐ One Way ☐ Round Trip

4 Transportation Needs (Please check ALL that apply):

- ☐ Patient CANNOT use public transportation due to a medical condition
- ☐ Patient is medically UNABLE to walk 4 blocks
- ☐ Patient is medically UNABLE to be driven by friend / family
- ☐ Patient is medically ABLE to use public transportation
- ☐ Patient requires a Wheelchair Vehicle
- ☐ Patient requires a Stretcher Vehicle
- ☐ Patient requires a Sedan (livery) Vehicle
- ☐ Patient needs companion for teaching / participation in medical care
- ☐ No multi-loading / immunosuppressed
- ☐ Other multi-loading restrictions: _____

Eligibility / Authorization Information:

Medicaid Covered Service

Medically Necessary / Appropriate

Notification made to: (Name of ASO): _____

The Service the Patient Requires Is Not Avai

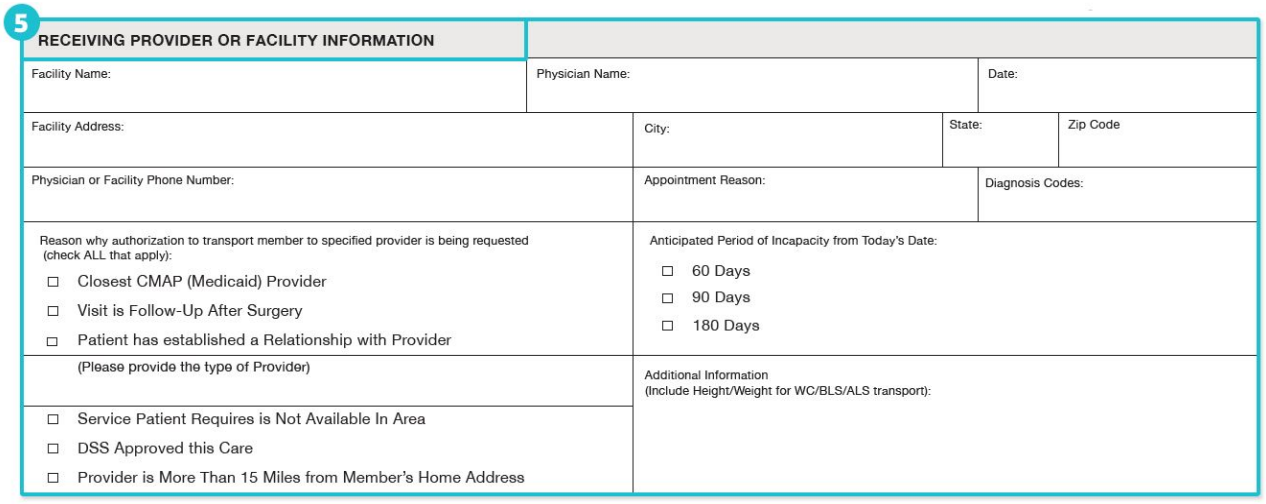
DSS Approval Required

Patient Referred to Closest Available Provid

Additional Information:

For a **Closest Provider Verification Override** — please fill out: **Name**, **MID**, **Date of Birth**, and on page 2 please fill out **section 5**.

Section 5, **The Receiving Facility Section** includes the verification of the facility the member is going to that is beyond the contractual mileage and please indicate the medical necessity for the appointment.



5 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):

- ☐ Closest CMAP (Medicaid) Provider
- ☐ Visit is Follow-Up After Surgery
- ☐ Patient has established a Relationship with Provider

(Please provide the type of Provider)

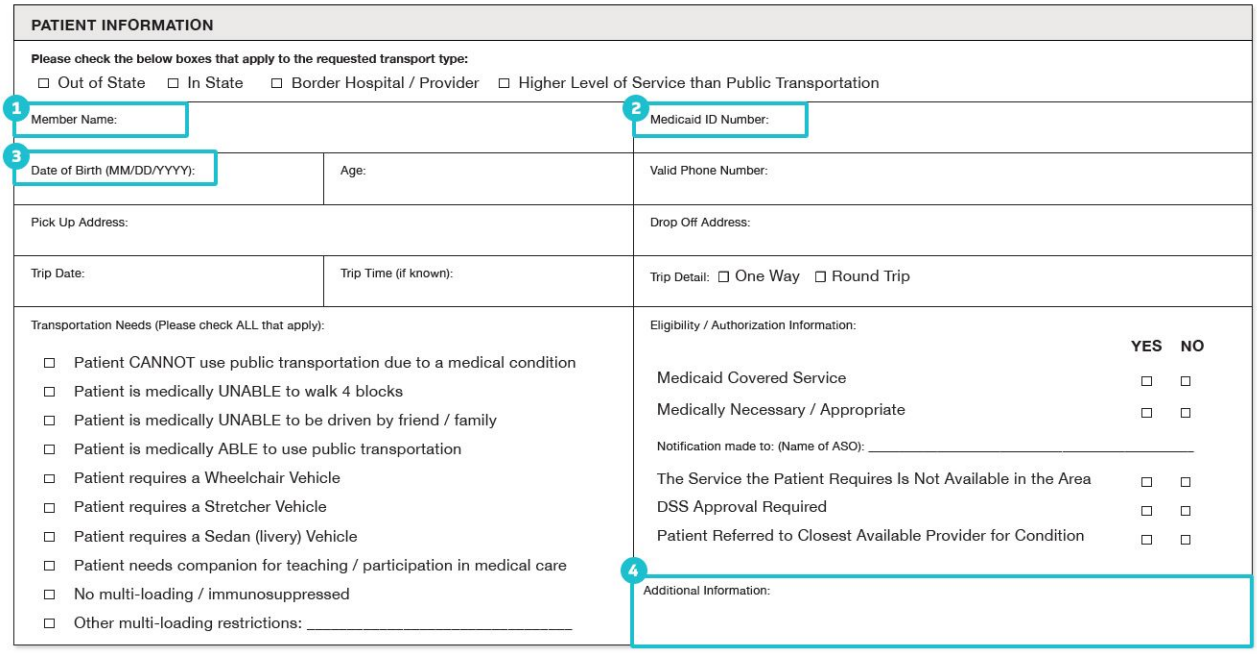
- ☐ Service Patient Requires is Not Available In Area
- ☐ DSS Approved this Care
- ☐ Provider is More Than 15 Miles from Member's Home Address

Anticipated Period of Incapacity from Today's Date:

- ☐ 60 Days
- ☐ 90 Days
- ☐ 180 Days

Additional Information
(Include Height/Weight for WC/BLS/ALS transport):

For a **Companion Request Override** — Please fill out: **1. Name**, **2. MID, 3.Date of Birth**, and **4.** on page 1, please indicate in the **"Additional Information"** section. Please state that the member will require a companion and reason why they cannot travel alone.



PATIENT INFORMATION

Please check the below boxes that apply to the requested transport type:

☐ Out of State ☐ In State ☐ Border Hospital / Provider ☐ Higher Level of Service than Public Transportation

1 Member Name:	2 Medicaid ID Number:
3 Date of Birth (MM/DD/YYYY): / Age:	Valid Phone Number:
Pick Up Address:	Drop Off Address:
Trip Date: / Trip Time (if known):	Trip Detail: ☐ One Way ☐ Round Trip

Transportation Needs (Please check ALL that apply):

- ☐ Patient CANNOT use public transportation due to a medical condition
- ☐ Patient is medically UNABLE to walk 4 blocks
- ☐ Patient is medically UNABLE to be driven by friend / family
- ☐ Patient is medically ABLE to use public transportation
- ☐ Patient requires a Wheelchair Vehicle
- ☐ Patient requires a Stretcher Vehicle
- ☐ Patient requires a Sedan (livery) Vehicle
- ☐ Patient needs companion for teaching / participation in medical care
- ☐ No multi-loading / immunosuppressed
- ☐ Other multi-loading restrictions: _____

Eligibility / Authorization Information:

	YES	NO
Medicaid Covered Service	☐	☐
Medically Necessary / Appropriate	☐	☐

Notification made to: (Name of ASO): _____

The Service the Patient Requires Is Not Available in the Area	☐	☐
DSS Approval Required	☐	☐
Patient Referred to Closest Available Provider for Condition	☐	☐

4 Additional Information:

For all **Out of State Transportation Needs** — or any situation that require DSS approval prior to transport, as well as for CHN post discharge appointments, the entire form (both pages) needs to be filled out for faster and accurate processing.