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

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

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: ☐ 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	☐	☐

Additional Information:

HOSPITAL / DISCHARGING FACILITY CONTACT INFORMATION

Your Full Name:	Phone Number:	Pager Number:
Email Address:	Additional Information (if any) / Urgent Rationale:	**Prior Authorization #**:

For out of state / higher level of care please send to: CTOutofState@veyo.com. All other requests please fax to: 860-724-2159 or to: ctcc@veyo.com

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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):

X

Licensed Health Care Provider Signature | Print Name Legibly | Date

TO BE COMPLETED BY VEYO

Please check the level of service for requested trip:

☐ Mileage Reimbursement ☐ Public Transit ☐ Paratransit ☐ Ambulatory ☐ Wheelchair ☐ ALS ☐ 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

DSS Approval Signature | Print Name Legibly | Date

Last revised date: December 6, 2018

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)

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