Non-Emergency Medical Transportation (NEMT)
Medical Necessity Form

This form is to be completed by a licensed health care provider. It is the member's responsibility to make sure this form is received by Veyo.

This form has five (5) parts:

Part A: Member Information (Required)

Name	DOB	Medicaid ID	Phone Number

Street Address	City	State	ZIP Code

This address is a:

☐ Home ☐ SNF / Residential Facility (Please fill out Part B) ☐ Other _____

Part B: Facility Information for Member

Name	Fax Number

Contact Name	Contact Direct Phone Number

Part C: Transportation Needs

Please indicate the most medically appropriate mode of transport for the member.

☐ Public Transit
☐ Driven by Friend / Family
☐ Livery / Medical Cab
☐ Wheelchair Transport (Width of Chair _____)
☐ Stretcher Transport
☐ Bariatric Wheelchair Transport (Width of Chair _____)
☐ ALS / BLS

Does the member have a preferred provider? ☐ Yes ☐ No	Name of Preferred Provider

Diagnosis Code(s)	Diagnosis is ☐ Temporary ☐ Permanent

Does the member have any of the following impairments?

☐ Muscular / Motor
☐ Cardiac Function
☐ Respiratory
☐ Cognitive / Psychological
☐ Other
☐ N/A

Please indicate the medical necessity to support why the mode is being requested. Please document all conditions that apply.

Member is unable to:

☐ Utilize public transit due to medical condition
☐ Be driven by friend / family due to medical condition
☐ Walk
☐ Sit in a wheelchair
☐ Bear weight
☐ Transfer
☐ Other _____

Member requires:

☐ Continuous oxygen therapy
☐ Continuous monitoring by a certified EMT or paramedic
☐ Life-sustaining equipment during transport
☐ Restraints
☐ Escort
☐ Other _____

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Part D: Mileage Override Request

The requested transportation will go beyond the allotted mileage for:

☐ Urban Areas (10 Miles) ☐ Rural Areas (20 Miles)

Destination Facility Name		Phone Number	
Street Address	City	State	ZIP Code

Please indicate the reason why the requested authorization to transport the member, or mileage reimbursement for the trip, is beyond the allotted mileage.

☐ Closest CMAP Provider
☐ Follow-Up After Surgery
☐ DSS Approved This Care
☐ Current Ongoing Treatment (Please Explain): _____

Part E: Additional Information

Please indicate any additional details relevant to this request.

☐ Member requires companion for teaching / participation in medical care
☐ Member is a MINOR (under 18 years of age)
☐ No multi-loading / immunocompromised (please explain): _____
☐ Information needed to support decision (please explain): _____

_____ _____

Licensed Health Care Provider Signature | Please Print Name

_____ _____

Provider Contact Telephone / Email | Date

Please send all requests to FAX: 860-724-2159 or email: ctcc@veyo.com

DSS Review and Approval Contacts
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