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 four (4) 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 _____

Diagnosis Code(s)	Diagnosis is
	☐ Temporary ☐ Permanent

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 (Bus Pass)
☐ Private Transportation (Gas Reimbursement)
☐ Livery / Medical Cab Arranged by Veyo
☐ Wheelchair Transport (Width of Chair _____)
☐ Bariatric Wheelchair Transport (Width of Chair _____)

Does the member have a Preferred Transportation Provider? ☐ Yes ☐ No

Name of Preferred Transportation Provider

Does the member have any of the following impairments that affect their transportation needs?

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

Please explain the specific physical or mental limitations checked off above that limit the member's ability to ambulate without assistance.

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):

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Member Information

Name

Part D: Mileage Override Request

Destination Facility Name		Phone Number	
Street Address	City	State	ZIP Code
Destination Facility Name		Phone Number	
Street Address	City	State	ZIP Code
Destination Facility Name		Phone Number	
Street Address	City	State	ZIP Code
Destination Facility Name		Phone Number	
Street Address	City	State	ZIP Code
Destination Facility Name		Phone Number	
Street Address	City	State	ZIP Code
Destination Facility Name		Phone Number	
Street Address	City	State	ZIP Code
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
- ☐ Current Ongoing Treatment (Please Explain):
- ☐ Follow-Up After Surgery
- ☐ DSS Approved This Care

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may be subject me to civil and criminal liability.

Licensed Health Care Provider Signature and Professional Designation*	Please Print Name	Provider Contact Telephone / Email	Date

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

Veyo Clinical Coordinator
Jaime Gallion, RN BSN, jgallion@veyo.com

Last revised date: May 19, 2020

* The forms will not be processed if the signature is not by a licensed provider and/or does not contain the professional designation