



# 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. The form will not be processed for the requested authorizations if it is missing medical necessity information or justification. Please ensure that the form is completed accurately and appropriately for approval.

This form has five (4) parts:

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## Part A: Member Information (Required)

Name	DOB	Medicaid ID	Phone Number
Street Address	City	State	ZIP Code
This address is a: <input type="checkbox"/> Home <input type="checkbox"/> SNF / Residential Facility (Please fill out Part B) <input type="checkbox"/> Other _____			
Diagnosis Code(s)	Diagnosis is <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent		

## Part B: Facility Information for Member (Required)

Name	Fax Number
Contact Name	Contact Direct Phone Number
Contact Email (Required for confirming approval or denial of form)	

## Part C: Transportation Needs (Required for non-Public Transit requests)

Please indicate the most medically appropriate mode of transport for the member.		
Public Transit (Bus Pass)	Wheelchair Transport	Bariatric Wheelchair Transport
Private Transportation (Gas Reimbursement)	(Width of Chair _____)	(Width of Chair _____)
Livery / Medical Cab Arranged by Veyo		
Does the member have a Preferred Transportation Provider? Yes <input type="checkbox"/> No <input type="checkbox"/>		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	No multi-loading / immunocompromised (please explain): _____	
Member is a MINOR (under 18 years of age)	Information needed to support decision (please explain): _____	



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**Member Information**

Name
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**Part D: Mileage Override Request (Required for trips over the mileage)**

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
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
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**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: October 27, 2020

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