Community Health Plan
OF IMPERIAL VALLEY | ADVANTAGE PLUS

NEMT - PHYSICIAN CERTIFICATION STATEMENT FORM

☐ **Routine** ☐ **Urgent** (Referral is considered Urgent when the member's life, health or ability to regain maximum function is seriously jeopardized, based on the prudent layperson's judgment or when the patient's practitioner determines that the member would be subjected to severe pain that cannot be adequately managed without the care that is being requested).

Please fill out this form legibly and completely. Incomplete requests may be returned.
Updated clinical documentation is required.

MEMBER INFORMATION

Member's Name: _____ DOB: _____ ID#_____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____Email: _____

Transportation of a Minor.

☐ State and Federal Law does NOT require parental/guardian consent for the transportation of a minor.

☐ By checking this box you are providing consent to transport minor unaccompanied to destination noted below for dates of service requested on this form.

Parent/legal guardian name: _____ Phone number:_____

Signature: _____ Date: _____

NEMT - FUNCTION LIMITATIONS JUSTIFICATION

For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public/private vehicles.

ICD10/Diagnosis:

☐ (N18.6) End Stage Renal Disease (ESRD)

☐ (J44.9) Chronic Obstructive Pulmonary Disease (COPD)

☐ (I50.22) Congestive Heart Failure (CHF)

☐ (E11.9) Type 2 Diabetes Mellitus (DM II)

☐ (I10) Hypertension

☐ (J96.90) Respiratory Failure

☐ (I63.9) Cerebral Infarction, unspecified, CVA

☐ F03.90 Unspecified Dementia

☐ Other: Please provide ICD-10 code with full description: _____

Physical and Medical Limitations:

☐ Unable to stand or walk without assistance

☐ Frequent falls due to unstable gait

☐ Cognitive impairment requiring supervision and queuing

☐ Breathing problem/low oxygen levels

☐ Unable to perform activities of daily living due to physical deficits

☐ Bed Bound with maximum assistance

☐ Wheelchair bound with assistance

☐ Other, please describe the limitations:

_____

_____

_____

_____

MODE OF TRANSPORTATION NEEDED

MCP'S are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services.

Please select ONE of the following modes of transportation based on the member's physical and medical need:

☐ **Ambulance:**

- ☐ American Medical Response (AMR) (for CCT only)
- ☐ Other: _____

☐ **Gurney/Litter Van:** All companies listed under "Ambulance" (except AMR) can also provide gurney transportation, designate under "other".

- ☐ Valley Medical Transport
- ☐ Other: _____

☐ **Wheelchair Van:**

- ☐ Valley Medical Transport
- ☐ Other:_____

☐ **Air Transport:**

Air Transportation Providers: This will be on a case-by-case basis with a Letter of Agreement (LOA).

TRANSPORTATION INFORMATION

Authorizations may be for a maximum of 12 months. **Start and end date cannot be the same.**

Start Date: _____ End Date: _____

Please note that authorizations are address specific. Any changes will require a new authorization.

FROM: ☐ Member's Home ☐ Facility ☐ Name of Location: _____

Address: _____

_____

TO: ☐ Specialist ☐ PCP ☐ Other _____

Name of Location: _____

Address: _____

Appointment(s)Date(s): _____

_ **OR**

TO: ☐ Dialysis - Appointments per Week Days: M☐ T☐ W☐ T☐ F☐ S☐ S☐

Name of Location: _____

Address: _____

_____

Miles per trip (One Way) : _____ ☐ Round trip ☐ One way Total Miles per Appointment: _____

CERTIFICATION STATEMENT

Prescribing provider is responsible for certifying that medical necessity was used to determine the type of transportation being requested.

Provider's Name: (Print) _____ Date: _____

Provider's Signature: _____ NPI: _____

Phone Number: _____ Fax Number: _____

PLEASE FAX THE COMPLETED FORM TO:
OUTPATIENT FAX NUMBER 1(760) 457-3008
INPATIENT FAX NUMBER 1(760)457-3010

NOTICE: YOU MUST SUBMIT A **NEW PCS FORM**, ANY TIME YOU NEED **MORE TRIPS OR MODIFICATIONS**.