# NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) REQUIRED JUSTIFICATION

In order to appropriately evaluate your request, **complete all form fields** below including **physician signature** and **date** of **signature**. If any field is incomplete, further documentation may be requested. **This form constitutes a prescription.** [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323 and the Medi-Cal Provider Manual]

1. Patient's name

2. Medi-Cal I.D. number

3. The current Skilled Nursing Facility (SNF) face sheet is:

☐ attached, since this patient currently resides in a SNF.

☐ not applicable, since this patient resides at home.

4. Dates of Service (DOS)

From: _____ To: _____

5. Appointment time

Start: _____ ☐ am ☐ pm End: _____ ☐ am ☐ pm

6. Days(s) of the week transported to above appointment(s)

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

7. Documentation is attached

☐ attached, since transport *is not to the nearest* facility that can meet the patient's medical needs.

☐ not applicable, as transport is to the nearest facility that can meet the patient's medical needs.

8. Diagnosis specific to visit(s)

9. Medical purpose/justification for visit(s)

10. The prescribed treatment plan including problems, interventions, and goals (along with why original goals were not met, if this is a reauthorization TAR)

☐ is attached, since request is for *multiple* transports that are *ongoing to same provider* for *same chronic diagnosis*.

☐ is not applicable, since request is for a single transport for a routine visit or one-time medical event.

11. Patient mobilizes via:

☐ Wheelchair ☐ Walker ☐ Cane ☐ Other (describe):

12. Functional limitations, (specific *physical* or *mental*), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: *(If more space is needed, please attach another page.)*

13. Based on 11 and 12, above, the required mode of transport is:

☐ Wheelchair van ☐ Gurney or litter van ☐ Ambulance

14. Physician signature (Physician's personal signature only. No proxy. No stamps.)

15. Date

16. Physician specialty (print or type)

17. License number

18. Physician name (print or type)

19. Telephone number (Area code and number)

( )

20. Physician address (number, street, city, zip code)