INSTRUCTIONS

1. Print or Type clearly.
2. Transportation must be by least expensive alternative which provides the necessary safeguards.
3. Must be submitted within 3 months of service.
4. Receiver certification is not an indication of admittance.

TRANSPORTATION AUTHORIZATION CERTIFICATE
MHCC-15 Rev. 8/07

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

FOR BUSINESS OFFICE USE
I.D. NUMBER

A. IDENTIFICATION/AUTHORIZATION CERTIFICATION (To be completed by PHYSICIAN, RECEIVER and/or PROVIDER for ALL transportation)

PATIENT NAME (Last) (First) (Middle)				PATIENT BIRTH DATE
PATIENT ADDRESS (No. and Street) (City or Town) (State) (Zip))				PATIENT SOCIAL SECURITY NUMBER
TRANSPORTATION PROVIDED	FROM	FACILITY CODE	TOWN CODE	TIME DISPATCHED : AM PM
	TO	FACILITY CODE	TOWN CODE	TIME ARRIVED : AM PM

REASON FOR TRANSPORTATION (Must be filled out!)	**TRANSPORTATION MUST BE TO A STATE-OPERATED INPATIENT FACILITY**			
	1. Psychiatrically Disabled Patient ☐ 17a-502 (Complete lines 1,2, and 4 below)	2. Voluntary Psychiatrically Disabled Patient ☐ (Complete lines 3 and 4 below)	3. Emergency Substance Abuse Treatment ☐ 17a-684 (Complete lines 1,2, and 4 below)	4. Voluntary Substance Abuse Treatment ☐ (Complete lines 3 and 4 below)
1. TRANSPORTATION AUTHORIZED	**TYPE OF TRANSPORTATION AUTHORIZED** (Examining physician must check one) [ ] Commercial Invalid Coach [ ] Ambulance [ ] Other			
2. PHYSICIAN	DATE (Mo., Day, Yr.)	Conn. Medical License No.	SIGNED: (Examining physician)	
3. TREATMENT PROVIDER CERTIFICATION	Provider hereby certifies that patient named above requested the transportation provided.		SIGNED: (Authorized treatment provider representative)	

B. RECEIVING FACILITY CERTIFICATION

I hereby certify that _____ was transported to _____
Name of Patient *Name of Facility*
for the primary presenting problem of substance abuse or dependence or psychiatric disability by _____
Name of Ambulance Company
on _____ at _____ [ ] AM [ ] PM

I hereby certify that prior to transporting the patient, the transportation provider obtained approval for transport from this facility.

4. RECEIVER CERTIFICATION	DATE (Mo., Day, Yr.)	SIGNED: (Receiving facility representative)
	PRINTED NAME OF AUTHORIZED OFFICIAL	

C. AMBULANCE COMPANY CERTIFICATION (To be completed for ALL Transportation)

I certify that a reasonable attempt was made to obtain payment from the transported patient and to determine that no third party is liable for payment of the transportation expenses. Evidence of these efforts shall be presented to DMHAS upon request.

SIGNATURE OF AUTHORIZED OFFICIAL OF AMBULANCE COMPANY	DATE

D. BUREAU OF COLLECTION SERVICES (For Bureau of Collection Services use <u>ONLY</u>)

Did patient have ability to pay at time of admission? [ ] YES [ ] NO (If "YES", provide financial explanation below)

RECOMMENDED BY (Name – PRINT or TYPE)		TITLE
FIELD OFFICE	DATE (Mo., Day, Yr.)	SIGNED