PARTNERSHIP HEALTHPLAN of CALIFORNIA

# Non-Emergency Medical Transportation (NEMT) Required Justification

In order to appropriately evaluate your request, **complete all form fields** below including **provider 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, PHC Policy MCCP2016, APL 17-010 and the Medi-Cal Provider Manual]

| 1. Patients Name | 2. Medi-Cal I.D. number |
|---|---|
| | |

3. Dates of Service (DOS)

From: _____ To: _____

Please complete for the desired date range of NEMT justification. Not to exceed 12 months and dependent on member eligibility.

4. Patient mobilizes via:

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

5. 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 patient can utilize taxi, public transport or gas mileage reimbursement please indicate this here.)*

☐ Patient is wheelchair bound an unable to self-transfer ☐ Dialysis ☐ Other (describe):

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

- ☐ Public Transport – Member is capable of utilizing local bus or para-transit system without assistance
- ☐ Taxi – Member can get from their home to the vehicle and transfer without assistance
- ☐ Wheelchair Van – Member must be transported by wheelchair because of disabling physical or mental limitation or is unable to self-transfer
- ☐ Gurney Van – Member must be transported in a prone or supine position because member is incapable of sitting upright
- ☐ Ambulance – Member's medical condition prevents the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)
- ☐ Air Ambulance – Member's medical condition prevents the use of ground transport (describe):

| 7. Provider signature (Acceptable signatures: MD, DO, PA, NP, CNM, Physical, Speech & Occupational Therapists, and Mental Health/Substance use disorder providers. Personal signature only. No proxy. No stamps)<br>*I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.* | 8. Date |
|---|---|
| | |

| 9. Provider specialty (print or type) | 10. License number |
|---|---|
| | |

| 11. Provider address (number, street, city, zip code) | 12. Telephone number (With area code) |
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