Health Plan of San Joaquin

Mountain Valley Health Plan

Physician Certification Form - Request for Transportation

This form will be used by Health Plan of San Joaquin/Mountain Valley Health Plan ("Health Plan") to determine the appropriate level of service for members.

Patient's Name: _____

Patient's Health Plan ID Number: _____ Patient's D.O.B.: _____

Patient's Date of Service From: _____ To: _____

Non-Emergency Medical Transportation (NEMT)

NEMT includes ambulance, wheelchair, air transport and gurney vans, and is provided when medically necessary and the member is not ambulatory. The NEMT transportation under Medi-Cal is covered only when the member's medical and physical condition does not allow them to travel by bus, passenger car, taxicab, or another form of public or private conveyance.

☐ Patient requires NEMT:

Please include the specific physical, medical or mental limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles. Please include ICD 10 code(s) below. Failure to complete this section will cause the PCS to be sent back to you for completion.

_____

ICD 10 Code (s): _____

Will the patient use one of the following during the transport? ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other (describe)

_____

Based on the above, what type of transportation does the member require? (CHOOSE ONLY ONE)

☐ Wheelchair ☐ Air Transport ☐ Ambulance BLS

CERTIFICATION

This Certificate can be completed and signed by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or a physician extender who is employed or supervised by the hospital, facility or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this Certificate.

Duration (based on continued health plan eligibility):

☐ Number of trips ___ ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 months ☐ 12 months

By signing this, I certify that medical necessity was used to determine the type of transportation being requested.

Physician's/Physician Extender's Name (print): _____

Physician's Specialty: _____

Physician's/Physician Extender's Signature: X_____ Title _____

Date: _____ Contact Phone no.: _____

Please return to Health Plan by fax at: 209-942-6302

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