Non-Emergency Medical Transportation (NEMT) Authorization Request

☐ **Routine: Fax to 714-338-3153** ☐ **Retrospective: Fax to 714-338-3153** ☐ **Urgent: Fax to 714-571-2424***

***If services required in less than 48 hours, also call the Transportation Coordinator at 714-347-5734**

MEMBER INFO

Patient Name: _____ ☐ F ☐ M Date of Birth: _____ Age: _____

Medi-Cal Number (CIN): _____ Preferred language: Spoken: _____ Understands: _____

Patient Address: _____ City: _____ Zip: _____ Phone: _____

☐ Home ☐ Board and Care ☐ ICF-DD ☐ SNF ☐ Other: _____

Facility Name: _____ Contact: _____

Facility Contact Direct Telephone Number: _____ Fax Number: _____

Primary Dx: _____ ICD-9: _____ Is this Member under Conservatorship? ☐ Y ☐ N

PRESCRIPTION AND MEDICAL NECESSITY CRITERIA *(Rx must be completed, signed and dated by attending physician)*

Prescribing Physician: _____

NPI # _____

Phone: _____ FAX: _____

Address: _____

Primary Care Physician (PCP): _____

NPI # _____

Phone: _____ FAX: _____

Address: _____

NEMT required to receive medical services on: Date: _____ Time: 12 59 p.m

With: Name: _____ Telephone Number: _____

Approximate duration of NEMT need: _____ Patient's current NEMT Provider: _____

Ambulance, Litter/Gurney van and Wheelchair van medical transportation services are covered 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 purposes of obtaining needed medical care. *Diagnosis alone does not constitute medical necessity.*

Please mark Member's qualifying medical necessity criteria: ** Attach medical records to substantiate medical necessity

Ambulance: *Member meets following medical necessity criteria:*

☐ Member's medical condition contraindicates the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)

Litter / Gurney van: *Member meets following medical necessity criteria:*

☐ Member must be transported in a prone or supine position because Member is incapable of sitting for the period of time needed to transport

Wheelchair van: *Member meets following medical necessity criteria:*

☐ Member must be transported by wheelchair because of a disabling physical or mental limitation and is unable to self-transfer or self-propel

M. D. / D. O. / D. D. S. Signature: _____ Date: _____

AUTHORIZATION *(For CalOptima Use Only)*

Eligibility Date: _____ Other Health Coverage: ☐ Medicare ☐ Other _____ ☐ SOC ☐ N/A

Utilization Contact: _____ Phone: (_____)_____-_____ FAX: (_____)_____-_____

Approved Codes: _____

Provider: _____

Authorization #: _____ Date Approved: _____ Date Sent: _____ By: ☐ FAX ☐ Mail

Records Attached: ☐ Progress Notes ☐ H&P ☐ Therapy Notes ☐ Operative Report ☐ Acute/LTC facility Notes

☐ **Denied** M.D. Signature: _____ Date: _____