

## 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:	
<input type="checkbox"/> attached, since this patient currently resides in a SNF. <input type="checkbox"/> not applicable, since this patient resides at home.	
4. Dates of Service (DOS) From: _____ To: _____	5. Appointment time Start: _____ <input type="checkbox"/> am <input type="checkbox"/> pm End: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
6. Days(s) of the week transported to above appointment(s) <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	
7. Documentation is attached	
<input type="checkbox"/> attached, since transport <i>is not to the nearest</i> facility that can meet the patient's medical needs. <input type="checkbox"/> 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)	
<input type="checkbox"/> is attached, since request is for <i>multiple</i> transports that are <i>ongoing to same provider for same chronic diagnosis</i> . <input type="checkbox"/> is not applicable, since request is for a single transport for a routine visit or one-time medical event.	
11. Patient mobilizes via:	
<input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Other (describe): _____	
12. Functional limitations, (specific <i>physical</i> or <i>mental</i> ), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: <i>(If more space is needed, please attach another page.)</i>	
13. Based on 11 and 12, above, the required mode of transport is:	
<input type="checkbox"/> Wheelchair van <input type="checkbox"/> Gurney or litter van <input type="checkbox"/> 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)	