

Physician Certification Statement (PCS)

For Non-Emergency Transportation (NEMT)

Fax: (415) 357-1292 / Telephone: (415) 547-7818 ext. 7080

**SAN FRANCISCO
HEALTH PLAN™**



Here for you

***Note-** Please submit this form with a Prior Authorization Form (PA)

Patient Information:

Patient Name: _____

SFHP ID #: _____ Telephone #: _____

Gender: Male Female Other

Address: _____

City: _____ State: _____ Zip: _____

Physical Justification Statement:

Please document the patient's limitations and provide specific physical & medical limitations that preclude the patient's ability to reasonably ambulate without assistance or be transported by public or private vehicle:

Please specify the dates of services needed:

Please specify the mode of transport needed:

1. NEMT ambulance services
2. Litter van services
3. Wheelchair van services
4. NEMT by air

I, _____, certify this patient meets medical necessity for this type of transportation

Sign: _____ Date: _____