

**Authorization Request for
Non-Emergency Transportation (NEMT)
and Physician Certification Statement (PCS)**

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

**The entire form must be completed prior to submission to SFHP.*

**SAN FRANCISCO
HEALTH PLAN™**



Here for you

Patient Name: _____ **Date of birth** _____

SFHP ID: _____ **Language** _____ **Height/Weight** _____

Pick up address: _____

Drop off address: _____ **Telephone:** _____

Does pickup/drop off location have stairs? _____ **How many?** _____ **Bariatric transport needed?** _____

Specialty equipment needed for pickup/drop-off/transport? _____

Service Codes (HCPCS/CPT): _____ **Units** _____

Dates of Service Needed: _____ **Ongoing?** Y N

Prescribing provider: _____

Clinic/facility: _____

Phone: _____ **Fax:** _____

Contact name: _____

Transportation Vendor: _____

Vendor NPI #: _____

Phone: _____ **Fax/Email:** _____

Contact name: _____

Medical Necessity Justification (must be filled out by prescribing provider)

Transportation related diagnoses (ICD-10 code(s)): _____

Ambulance, air ambulance, gurney/litter van and wheelchair van medical transportation services are covered when the member's medical 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.

Mode of transport needed:

NEMT ambulance services: Member's medical condition contraindicates the use of other forms of medical transportation. (Member requires specialized equipment and/or personnel.)

Reason: _____

Gurney/litter van services: Member must be transported in a prone or supine position because member is incapable of sitting for the period of time needed to transport.

Reason: _____

Wheelchair van services: Member must be transported by wheelchair because of a disabling physical or mental limitation and is unable to self-transfer or self-propel.

Reason: _____

Air ambulance: Member's medical condition or practical consideration render ground transportation not feasible.

Reason: _____

Prescribing provider certification of medical necessity (must be signed by prescribing provider)

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

Ordering provider signature: _____ **Date:** _____