San Francisco Health Plan Transportation Important Provider Reminders

San Francisco Health Plan

SFHP COVERS TWO TYPES OF TRANSPORTATION

Non-Emergency Medical Transportation (NEMT)*

Available to Medi-Cal and Healthy Workers HMO members when their medical and/or physical condition (i.e. functional limitation) makes using typical forms of public and private transportation harmful to their health.

NEMT includes these modes of transport:

- Wheelchair Van
- Gurney/Litter Van
- Ambulance (BLS & ALS)
- Air Ambulance

NEMT requires a provider's prescription and authorization from SFHP.

***SFHP's NEMT Authorization/Physician Certification Statement (PCS) form is attached below.**

Non-Medical Transportation (NMT)*

Available to Medi-Cal members who have no other way to get to their Medi-Cal covered service. NMT does not include transportation of people who are sick, injured, recovering from sickness, or otherwise incapacitated.

NMT includes these modes of transport:

- Public Transportation/Mass Transit
- Ambulatory Curb-to-Curb
- Ambulatory Door-to-Door
- Private Vehicle arranged by patient (additional verification information needed for approval)

***NMT does not require a provider's prescription.**

SFHP partners with Modivcare to arrange NMT and NEMT.

Providers can request rides 24 hours a day, 7 days a week through Modivcare's dedicated provider phone line at **1(866) 529-2128** or online through the TripCare Portal.

TRANSPORTATION REQUESTS

NMT REQUESTS

Providers may directly request NMT without pre-approval from SFHP.
The attached PCS form is not required.

Provider Requests
Use the TripCare Portal or call the Modivcare Facility Line at **1(866) 529-2128.**

Member Requests
Members should call SFHP Customer Service at **1(415) 547-7800,** Monday–Friday, from 8:30am–5:30pm.

NEMT REQUESTS

SFHP approval must be obtained before requesting NEMT.
Please include your contact information on the PCS form, and SFHP will fax you an approval letter.

Provider Request
After SFHP approval is received, use the TripCare Portal or call Modivcare Facility Line at **1(866) 529-2128.**

Member Request
Members should call Modivcare Customer Service at **1(855) 251-7098.**

Routine Appointments Request transportation through TripCare or by calling at least five (5) business days before the appointment.

Urgent Appointments Call as soon as possible.

For more information, visit Transportation Services and Non-Emergency Transportation (NEMT) FAQ.

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

San Francisco Health Plan℠

Telephone: **1(415) 547-7807** Email: **nemt@sfhp.org**
Fax: **1(415) 357-1292**

TYPED ONLY - NO HANDWRITTEN FORMS

THE PRESCRIBING PROVIDER MUST FILL OUT THEIR REQUIRED PORTIONS AS INDICATED BY ASTERISKS (*) THEN SUBMIT TO SFHP'S TRANSPORTATION COORDINATOR BY FAX OR EMAIL.

For ride requests, access Modivcare's TripCare Portal or Provider Line **1(866) 529-2128.**

*Patient Information

***Name:** ________________ ***Date of Birth:** ____/____/____ ***SFHP ID:** ________________

***Phone Number:** ____________ ***Address:** ________________ ***Height/Weight:** ________ / ________

***Select Type of Request:** ☐ **Routine** ☐ **Retro (must be submitted within 30 calendar days of date of service)**
☐ **Urgent (Select Reason):**
☐ Hospital Discharge ☐ Dialysis ☐ Other Urgent – Member's life, health, or ability to attain, maintain, or regain max function in serious jeopardy

***Select all that Apply:** ☐ **New** ☐ **Renewal** ☐ **Modality Modification (Upgrade/Downgrade)**

Physician Certification Statement - MUST BE FILLED OUT BY PRESCRIBING PROVIDER

***Function Limitations Justification:** Document member's **specific** physical and medical limitations that preclude the member's ability to reasonably ambulate with assistance or be transported by public or private vehicle (includes taxis and ambulatory door-to-door transport types).

____

***Related ICD-10 diagnosis code:** ________________________________

***Dates of Service Needed:**

☐ **One-Time Only *Date:**____/____/____

☐ **Ongoing (up to 12 months) *Start date of service:**____/____/____ ***End date of service:** ____/____/____

NEMT 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 obtaining medically necessary services.

***Mode of transport needed:**

☐ **Wheelchair Van Services (A0130):** Member is incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport or requires transport in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation or requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance. Ex: severe mental confusion, paraplegia, dialysis recipients, unmonitored oxygen use.

☐ **Gurney/Litter Van Services (T2005):** Member must be transported in a prone or supine position, because they are incapable of sitting for the period of time needed to transport and/or they require specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

☐ **Ambulance Services (Select one: ☐ Basic Life Support-A0428 ☐ Advanced Life Support-A0426 ☐ Specialty Care-A0434):** Member has a chronic condition requiring oxygen monitoring or has recently been placed on oxygen (does not apply to members with their own self-monitored oxygen equipment).

☐ **Air Ambulance (A0430):** Member's medical condition or practical consideration render ground transportation not feasible.

*****I certify that medical necessity was used to determine the type of transportation being requested.

***Prescribing Provider Name & Credential (print):** ________________ **Clinic/facility:** ____________

***Prescribing Provider Signature:** ________________________ ***Date:**____/____/____

Include contact information below. SFHP must be able to reach the provider's contact in the event the details on the PCS form are incomplete.

Contact name: ________________________ **Phone:** ____________ **Fax:** ____________

All fields with an Asterisk (*) are mandatory for Prescribing Provider.