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

SAN FRANCISCO HEALTH PLAN™
Here for you

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 SEND TO SFHP'S TRANSPORTATION COORDINATOR OR THE NEMT VENDOR TO COMPLETE AND SUBMIT.

*Patient Information

***Name:** _____ ***Date of Birth:** _____/_____/_____ ***SFHP ID:** _____

***Phone Number:** _____ ***Address:** _____ ***Height/Weight:** _____/_____

***Select Type of Request:** ☐ **Urgent** ☐ **Routine** ☐ **Retro (must be submitted within 30 calendar days of date of service)**

Physician Certification Statement (MUST BE FILLED OUT BY PRESCRIBING PROVIDER)

***Function Limitations Justification:** Document member's specific physical and medical limitations requiring assistance or precluding public or private vehicle use. _____

***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. Available for ambulatory members requiring support and/or supervision.

☐ **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 (Specify Ambulance Option: Basic Life Support-A0428** or **Advanced Life Support-A0426):** 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.

MUST BE FILLED OUT BY TRANSPORTION VENDOR OR SFHP'S TRANSPORTATION COORDINATOR

Transportation Vendor: _____ Vendor NPI #: _____

Phone: _____ Fax/Email: _____ Contact name: _____

Service Codes (HCPCS/CPT): _____ Units _____