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

Fax: **1(415) 357-1292** Telephone: **1(415) 547-7818 ext. 7080**

SAN FRANCISCO HEALTH PLAN™
Here for you

THE ENTIRE FORM MUST BE COMPLETED PRIOR TO SUBMISSION TO SFHP

TYPED ONLY - NO HANDWRITTEN FORMS

THIS FORM MUST BE SUBMITTED BY THE NEMT VENDOR. THE PRESCRIBING PROVIDER MUST FILL OUT THEIR REQUIRED PORTIONS THEN SEND TO THE NEMT VENDOR TO COMPLETE AND SUBMIT.

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

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

Pick up address: _____

Drop off address: _____ Telephone: _____

Does pick up/drop off location have stairs? _____ How many? _____ Bariatric transport needed? _____

Specialty equipment needed for pick up/drop off/transport? _____

Transportation Vendor: _____ Vendor NPI #: _____

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

Service Codes (HCPCS/CPT): _____ Units _____

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

Prescribing Provider: _____ Clinic/facility: _____

Phone: _____ Fax: _____ 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.

Prescribing Provider signature: _____ **Date:** _____