VA Operations
Utilization Review Department
798 Park Ave NW
Norton, VA 24273
PHONE: 866.679.6330
FAX: 866.885.3788

Level of Service Certification of Medical Necessity for Non-Emergency Ambulance, Stretcher and Wheel Chair Transport

In an effort to insure every member is transported by the most appropriate means necessary, LogistiCare may require completion of this form. If requested, please certify the level of service needed and fax to the number shown above.

Patient Information				Provider Information	
DOB: ____/___/____	Sex M F	Age	Medicaid ID #	Medicaid Provider #	Phone # ( )
Patient Name (Last, First, MI)				Provider Name & Address	

LEVEL OF SERVICE REQUIRED BY MEMBER & PRESCRIBED BY MEDICAL PROVIDER

Stretcher Transport	Wheelchair Transport
Stretcher/Ambulance ☐ Stretcher Van ☐	Manual ☐ Electric ☐ Width of Chair _____

Stretcher Van Transport is provided only for Members who do not require medical assistance during transport but are non-ambulatory and unable to use a wheelchair. Members using wheelchairs who also require medical assistance during transport should be referred to the appropriate level of ambulance transport.

Medical Equipment Needed	Medical Necessity Criteria	Medical Necessity Criteria (Cont.)
__ Airway Monitoring and/or Suctioning __ Oxygen __ Ventilator Dependent __ Other_____	__ Bed-Confined __ History of existing paralysis/CA __ Decubitus Ulcers/Cannot Sit Safely __ Hip/Leg/Back Precautions/Cannot Sit Safely	__ Contractures __ Confused/Lethargic/Comatose __ Cannot Support self while seated in a wheelchair for transport distance __ Other_____

Summary of Member's medical history establishing the medical necessity for the prescribed level of service: (Additional documentation may be attached when necessary.)

Estimated Duration of This Level of Service. Check One 60 Days ☐ 90 Days ☐ Ongoing ☐

Knowingly providing false information on this Certification may constitute fraud and may prevent the Member from receiving further transportation services. If you have any questions please contact LogistiCare's Facility Assistance Department at **866-679-6330**

I certify that to the best of my knowledge, the above information is true, accurate and complete and the level of service required for the Member's transport is medically necessary for the Member's health.

NAME: _____ **SIGNATURE:** _____ **DATE:** _____

This Certification may be completed and signed only by the Member's attending physician, physician's assistant or RN to confirm a medically necessary level of service. Please complete form and fax to (866) 885-3788.