Medical Necessity Form

Virginia Non-Emergency Transportation Services

Facility Department: Telephone 866-679-6330 Fax 866-907-1491

In an effort to insure every member is transported by the most appropriate means necessary, LogistiCare requires completion of this form. Please complete this form as accurately as possible and fax to the number shown above.

Member Name: _____ **Date of Birth:** _____

Member's Medicaid/MCO ID #:_____

Can Member ambulate without assistance?	☐ Yes	☐ No
Does Member use a walker or cane?	☐ Yes	☐ No
Does Member require a Wheelchair?	☐ Yes	☐ No
Is Member able to transfer (stand and pivot)?.....	☐ Yes	☐ No
Is Member bedbound (unable to stand and pivot/ambulate/sit upright)? (Must meet all 3 criteria to qualify for van stretcher and stretcher transport)	☐ Yes	☐ No
Does Member require special medical equipment (Pulse Ox, IVs, etc.)?	☐ Yes	☐ No
Does Member require medical monitoring?	☐ Yes	☐ No
Does Member require O2?	☐ Yes	☐ No
Can Member self-administer his or her own O2?	☐ Yes	☐ No
Is Member able to act as his or her own responsible party?.....	☐ Yes	☐ No
Will the Member have an escort?	☐ Yes	☐ No

Mode of Transportation Required:

☐ Ambulatory -- Taxi/Sedan/Mini Van (No special needs)
☐ Ambulatory -- Uses Wheelchair (Able to transfer safely in and out of a vehicle)
☐ Wheelchair Van – Uses Wheelchair (Unable to safely transfer in and out of a vehicle)
☐ Van Stretcher -- (Bed Confined and does not require any type medical monitoring)
☐ Stretcher -- (Bed confined requiring some type of medical monitoring)

If requesting wheelchair van, van stretcher or stretcher, please provide the qualifying ICD9 or

Diagnosis: _____

Comments:_____

_____

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_____ _____ _____

Physician's Signature | Physician's Printed Name | Date

I certify that the above information is true and correct based on my evaluation of this patient, and represent that due to the member's condition he or she requires transport by the mode requested on this form. I understand that this information will be used by LogistiCare and the Department of Medical Assistance Services (DMAS) to support the determination of medical necessity for services provided, and that I have personal knowledge of the patient's condition at the time of transport.