Request for Non-Emergency Medical Transportation (NEMT) Physician's Certification Statement

Fax: (323) 889-6506

Urgent Fax*: (323) 889-5403 Phone: (800) 468-9935 M-F 8 a.m. to 5 p.m.

This form authorizes the provider of transportation to provide Non-Emergency Medical Transportation (NEMT) needed by a Blue Shield of California Promise Health Plan Medi-Cal or Cal MediConnect member. NEMT includes ambulance, litter vans, gurney vans, wheelchair vans, and air transport, and is provided when it is medically necessary, and the patient is not ambulatory. NEMT under Medi-Cal is covered only when the patient's medical and/or physical condition does not allow them to travel by bus, passenger car, taxicab, or other form of public or private conveyance.

This form is not required for:
- Non-Medical Transportation (NMT)
- NEMT when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility

MEMBER

First Name	Last Name	ID Number	Date of Birth	Diagnosis
Address		**City**	**State**	**Zip**

TRANSPORTATION

◯ **Ambulance** Basic Life Support (BLS) ◯ **Ambulance** Advanced Life Support (ALS) ◯ **Ambulance** Specialty Care Transport (SCT)	◯ **Litter/Gurney van** ◯ **Wheelchair van** ◯ **Air**	**Effective Date**	**End Date** (max12 months)
Justification (required): Provide specific physical and medical limitations that preclude the member's ability to reasonably be ambulatory without assistance or to be transported by public or private vehicles.			

TRANSPORTATION PROVIDER (only needs to be completed if not Call the Car)

Name			
Address	**City**	**State**	**Zip**
Provider NPI	**Phone**	**Fax**	

PHYSICIAN

Full Name (print)		Title	
Address	**City**	**State**	**Zip**
Provider NPI	**Phone**	**Fax**	

CERTIFICATION: This certificate must be signed by an MD, DO, PA or NP who is employed or supervised by the hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate. The signatory must be the provider responsible for providing care to the member and responsible for determining medical necessity of transportation consistent with the scope of their practice. By my signature, I certify that medical necessity was used to determine the type of transport being requested.

Signature	Date

*To qualify as urgent, the request must meet California Health and Safety Code section 1367.01(h)(2).