

REFERRAL FORM FOR TRANSPORTATION SERVICES AND PHYSICIAN CERTIFICATION STATEMENT (PCS)

The Department of Health Care Services (DHCS) requires that a PCS Form is used to process and determine the appropriate level of Non-Emergency Medical Transportation (NEMT) services. Completed and signed forms must be promptly submitted to **Attn: MHMH Utilization Review (UR) Transportation Unit** via facsimile "fax" to: **909-438-1119**.

PCS forms for transportation that meet the criteria for **Automatic Approval (AA)** shall be submitted within 24 hours of NEMT services being arranged to document activity and avoid unnecessary delays. AA is typically for transports in response to discharges, transfers, dialysis, chemotherapy, mammogram, radiation treatment, and surgery follow-up appointments. All other PCS forms for **Prior Authorizations** must be reviewed and approved by UR team *before* NEMT services are arranged. Incomplete or inaccurate forms may cause delays and/or denials. Standard UR turn-around time is five (5) business days. The PCS Form is **not required for Non-Medical** Transportation (NMT) services. To schedule NMT, AA NEMT, or authorized NEMT, please call transportation.

Patient Information:

First Name:	Last Name:	Date of Birth:
ID Number / CIN#:	Phone Number:	
Address:		Caregiver Name:
City:	State:	Zip:
		Caregiver Phone Number:

Provider Information:

Provider's Full Name (Print):		
Title:	Provider NPI:	
Phone Number:	Fax Number:	Email:

Authorization Level: If request is for AA, please CHECK AA and CONFIRM vehicle type below.

Automatic Approval (AA) Prior Authorization

Does Patient Need Prior Authorization for NEMT? Complete the NEMT section below.

NEMT – PROVIDER CERTIFICATION, JUSTIFICATION & SIGNATURE REQUIRED

Disclaimer: MHMH is required to authorize the lowest cost type of NEMT services that is adequate for the member's medical needs. Once the PCS is submitted, we cannot modify the authorization to a lower level without a new PCS form from the provider.

NEMT Vehicle Type & Door-Through-Door

Ambulance:			
<input type="checkbox"/> Basic Life Support (BLS) <input type="checkbox"/> Advanced Life Support (ALS) Litter/Gurney Van	<input type="checkbox"/> Wheelchair Van	<input type="checkbox"/> Air Ambulance	
<input type="checkbox"/> Specialty Care Transport (SCT)			

NEMT Anticipated Duration:

Start Date:	End Date:	<input type="checkbox"/> 30 Days	<input type="checkbox"/> Six (6) Months	<input type="checkbox"/> 12 Months
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Justification: Provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles. Include medical, behavioral health, or the physical condition that prevents ordinary means of public transportation (provide justification here):

Diagnosis:	ICD-10 Code(s):
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Certification Statement: This form **must be signed** by the physician, physician assistant, nurse practitioner, certified nurse midwife, physical therapist, speech therapist, occupational therapist, dentist, podiatrist, mental health or substance use disorder 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 (Required): X _____	Date: _____
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