AUTHORIZATION

Please type into PDF form and fill out all fields.

Fax completed form to 650-829-2079

Authorization for Non-Emergency Medical Transportation Services and Physician Certification Statement

Non-emergency medical transportation is available to obtain medically necessary services when the patient's medical/physical condition does not allow them to travel by bus, passenger car, taxicab or other forms of public or private conveyance. HPSM will continue to accept PCS forms for Pharmacy services when authorizing NEMT including for Pharmacy Services after they are carved out from HPSM benefits for Medi-Cal Rx.

INSTRUCTIONS
The physician, dentist, podiatrist, mental health or substance use disorder provider responsible for providing care for the member is responsible for determining medical necessity for transportation.

MEMBER INFORMATION			
Member's Name:	**Member's Date of Birth:**		
Member's ID Number:	**Member's Phone Number:**		
Address:	**City:**	**State:**	**ZIP:**

DIAGNOSIS (Must support need for transportation)		
Primary Diagnosis Code:	**Description:**	
Procedure Code (CPT/HCPCS Code):	**Modifier:**	**Units of Service:**
Procedure Code (CPT/HCPCS Code):	**Modifier:**	**Units of Service:**
Procedure Code (CPT/HCPCS Code):	**Modifier:**	**Units of Service:**

PROVIDER INFORMATION	
Transportation Company:	**NPI:**
Phone Number:	**Fax Number:**

HealthPlan OF SAN MATEO
Healthy is for everyone

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DATES OF SERVICE NEEDED

☐ **One-Time Only:**

Date: _____

☐ **Ongoing (up to 12 months):**

Start Date: _____ **End Date:** _____

FUNCTION LIMITATIONS JUSTIFICATION

Please document and provide specific physical and medical limitations that preclude the patient's ability to reasonably ambulate with assistance, or be transported by public or private vehicles.

Treatment plan should include the medical, behavioral health, or the physical condition that prevents normal public or private transportation:

TYPE OF TRANSPORTATION

☐ **Ambulance** *(Specify A0426 or A0428)*

☐ **Litter van** *(Specify T2005)*

☐ **Wheelchair van** *(Specify A0130)*

☐ **Air** *(Specify A0430 or A0431)*

☐ Request is for multiple transports that are ongoing to the same provider for same chronic diagnosis; treatment plan is attached.

☐ Request is for multiple transports that are ongoing to different providers for any covered services. This includes minors accessing EPSDT covered services. Treatment plan is attached.

☐ Hemodialysis – Standing order, covered for 12-month period with unlimited trips.

☐ Other – Explain:

CERTIFICATION

This Certificate can be completed and signed by an MD, PA, NP, certified nurse midwives (CNMs), physical therapists, speech therapists, occupational therapists, mental health or substance use disorder providers who are 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.

I certify that medical necessity was used to determine the type of transportation requested.

Staff/Physician's Name: (print)	Date:
Staff/Physician's Signature:	NPI:
Phone Number:	Fax Number: