L.A. Care HEALTH PLAN

Prior Authorization Form

Non-Emergency Medical Transportation – Physician Certification Statement

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

TRANSPORTATION TYPE:					
Ambulance: ☐BLS ☐ALS	☐Litter/Gurney Van	☐Wheelchair Van	☐Air Transport		
ANTICIPATED TRANSPORTATION DURATION:					
Start Date:	End Date:	☐12 Month Interval	☐6 Month Interval	☐30 Days	☐Other (Specify)
PHYSICIAN CERTIFICATION STATEMENT: ***required for NEMT***					
The physician, dentist, podiatrist or mental health or substance use disorder provider responsible for providing care for the member is responsible for determining medical necessity for transportation. This certificate may be completed and signed by the member's physician, dentist, podiatrist or mental health or substance use disorder provider responsible for providing care for the member. By my signature I hereby certify that medical necessity was used to determine the type of transport being requested.					
REQUEST SUBMITTED BY: ***required for NEMT***					
Physician's Name: (Print)					
Title:			Physician NPI:		
Phone Number:			Fax Number:		
Physician Signature:			Date:		
DISCLAIMER:					
L.A. Care is required to authorize the lowest cost type of NEMT Transportation that is adequate for the member's medical needs. Once the member's treating physician prescribes the form of transportation, L.A. Care cannot modify the authorization.					
JUSTIFICATION: ***required for NEMT*** The physician is required to document and 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. Please utilize the section below for this purpose. Include medical, behavioral health, or the physical condition that prevents ordinary means of public or private transportation:					
DIAGNOSIS:					
Diagnosis:			ICD-10 Code:		
Diagnosis:			ICD-10 Code:		

Non-Medical Transportation (NMT)

TRANSPORTATION TYPE: ***Does not require physician signature***					
☐Taxi	☐Van	☐Sedan	☐Other (Specify)		
ANTICIPATED NON MEDICAL TRANSPORTATION DURATION REQUIRED:					
Start Date:	End Date:	☐12 Month Interval	☐6 Month Interval	☐30 Days	☐Other (Specify)

Staff Name: (Print)	**Date:**
Title:	
Phone Number:	**Fax Number:**

Please return form by facsimile to L.A. Care Attn: Utilization Review Transportation Unit Fax Number: 213-438-2201

An incomplete form will delay transportation request for member.

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