3989 E. Arapahoe Road Ste 120
Centennial, Colorado 80122
Facility Fax # 1-800-390-3184

LogistiCare

CLOSEST PROVIDER CERTIFICATION

Required for All Clients Traveling More Than 12 Miles Ambulatory or 50 Miles in a Wheelchair

IT IS THE PATIENT'S SOLE RESPONSIBILITY TO ENSURE THIS FORM IS RECEIVED BY LOGISTICARE

PATIENT INFORMATION				**PROVIDER INFORMATION**	
1.DOB	2.SEX M F	3. AGE	4. MEDICAID ID #	9. MEDICAID PROVIDER #	10. PHONE NUMBER ( )
5. PATIENT NAME (LAST, FIRST, MI)				11. PROVIDER NAME & ADDRESS	
6. STREET ADDRESS					
7. CITY, STATE, ZIP CODE					
8. PHONE NUMBER				**IS THIS A BHO COVERED SERVICE/FACILITY? Y N**	

REASON TREATMENT IS PROVIDED AT A DISTANT LOCATION

12. TYPE OF FACILITY (EX: MENTAL HEALTH, PCP, SPECIALIST, ETC.)	13. ARE YOU THE CLOSEST PROVIDER THAT CAN SEE THE CLIENT FOR THE TREATMENT BEING SOUGHT? YES ☐ GO TO BLOCK 15 NO ☐ GO TO BLOCK 14

14. SUMMARY OF WHY THE PATIENT NEEDS TO RECEIVE CARE AT YOUR LOCATION. GIVE SUFFICIENT DETAIL TO SATISFY MEDICAL NECESSITY FOR THE EXTENDED TRIP. (ADDITIONAL DOCUMENTATION MAY BE ATTACHED WHEN NECESSARY.)

15. FALSIFYING INFORMATION ON THIS DOCUMENT MAY CONSTITUTE FRAUD AND MAY PREVENT THE CLIENT FROM RECEIVING FURTHER TRANSPORTATION SERVICES THROUGH OUR OFFICE. IF YOU HAVE ANY QUESTIONS PLEASE CONTACT FACILITY ASSIST AT 1-800-390-3182.

To the best of my knowledge the above information is true, accurate and complete and the required services are medically necessary to the health of the patient.

Name: _____Signature: _____ Date: _____

Only a Physician, a Physicians Assistant or RN at the direction of a Physician may sign the above form in block 15.