



Phoenix 2 Operations  
 2602 S 47<sup>th</sup> ST  
 Phoenix, AZ 85034

## HI LEVEL OF SERVICE CERTIFICATION OF MEDICAL NECESSITY

Required for All Patients / Members Using Wheelchair or Stretcher Transport

FAX # 866-475-5745

PHONE # 866-475-5744

Patient / Member Information:				Medical Provider Information:	
DOB: ____/____/____	Sex M F	Age	Medicaid ID #	Medicaid Provider #	Phone # (     )
Patient / Member Name (Last, First, MI)				Medical Provider Name & Address	

### LEVEL OF SERVICE REQUIRED BY MEMBER & PRESCRIBED BY MEDICAL PROVIDER

Stretcher Transport <input type="checkbox"/> Stretcher <input type="checkbox"/> Stretcher Van <input type="checkbox"/>	Wheelchair Transport <input type="checkbox"/> Width of Chair _____
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Stretcher Transport is provided only for patients / Members who do not require medical assistance during transport but are non-ambulatory and unable to use a wheelchair. Patients / members using wheelchairs who also require medical assistance during transport should be referred to the appropriate level of ambulance transport.

Medical Equipment Needed	Medical Necessity Criteria	Medical Necessity Criteria (Cont.)
___ Airway monitoring and/or suctioning ___ Oxygen ___ Ventilator dependent ___ Other _____	___ Bed-confined ___ History of existing paralysis/CA ___ Decubitus ulcers / Cannot sit safely ___ Hip/leg/back precautions / Cannot sit safely	___ Contractures ___ Confused/lethargic/comatose ___ Cannot support self while seated in a wheelchair for transport distance ___ Other _____

Summary of Patient's / Member's medical history, including physical exams, laboratory results, and prescriptions, establishing the medical necessity for the prescribed level of service: (Additional documentation may be attached when necessary.)

Estimated duration of Level of Service. (check one)      60 Days       90 Days       Ongoing

Knowingly providing false information on this Certification may constitute fraud and may prevent the patient / Member from receiving further transportation services. If you have any questions please contact LogistiCare's Facility Assistance Department at **866-475-5744**

*I certify that to the best of my knowledge, the above information is true, accurate and complete and the level of service required for the patient's / Member's transport is medically necessary for the patient's / Member's health.*

**NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

This Certification may be completed and signed only by the patient's / Member's attending physician, physician's assistant or Registered Nurse to confirm a medically necessary level of service.

“Caution: This information contains confidential and proprietary trade secrets, the release of which could cause competitive harm. It is not subject to disclosure under any freedom of information act or open records act law or regulation. Do not further disclose.”