MI Operations
26877 Northwestern Hwy Ste 211
Southfield, MI 48033

MICHIGAN NON-EMERGENCY LEVEL OF SERVICE CERTIFICATION OF MEDICAL NECESSITY FORM

Required for All Patients / Members Requesting Transportation

FAX # 866-569-1910

PHONE # 866-569-1902

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

LEVEL OF SERVICE REQUIRED BY MEMBER & PRESCRIBED BY MEDICAL PROVIDER

Ambulatory ☐	Medivan (Door 2 Door) ☐
Wheelchair Transport ☐ Width of Chair: _____ Number of Stairs: _____	Wheelchair able to transfer ☐ Height: _____ Weight: _____ Ramp: ☐ Yes ☐ No

(Please document all conditions that apply)	Medical Necessity Criteria	(Please document all conditions that apply)
__ Independent Ambulation __ Uses walker or cane __ Walking difficulty __ Requires assistance of trained personnel safety	__ Alert __ Confused __ Disoriented __ Brings Escort __ Bed Confined __ Confined to wheelchair	__ Travels with Oxygen __ Requires Continuous Cardiac Monitoring __ O2 via trach requiring suctioning __ Risk of fall from chair/safety

__ Car/taxi/van (folding wheelchair patient able to make it to the curb alone)
__ Car/taxi/van (folding wheelchair patient unable to make it to vehicle alone)
__ Clinic van or car, ambulatory van or car (patient is able to make it to the curb alone)
__ Clinic van or car, ambulatory van or car (patient must have assistance to make it to the vehicle)
__ Wheelchair lift-equipped van (patient is able to make it to the curb alone)
__ Wheelchair lift equipped van (patient must have assistance to make it to the vehicle)

Estimated duration of the prescribed Level of Service is medically necessary 90 Days ☐ 6 Months ☐ 1 Year ☐

Knowingly providing false information on this Certification may constitute fraud and may prevent the Member from receiving further transportation services. If you have any questions please contact LogistiCare's Reservation Department at **866-569-1902**.

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 Member's transport is medically necessary for the Member's health

Physician or Certified Professional: PRINTED NAME/TITLE: _____

SIGNATURE: _____ _____**DATE:** _____

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