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

Required for MDHHS Beneficiary Requesting Door 2 Door / Wheelchair Transportation Service
Fax# 1-866-569-1910
Phone# 1-866-569-1902

Effective 2-1-2020 Medical Necessity Forms are mandatory for Medivan and Wheelchair services only.		**Medicaid Provider #**	**Facility Phone #** ( )
Patient Name (Last, First, MI)			**Medicaid Provider Name & Address**
D.O.B ____ / ____ / _____	**Sex (circle)** M F	**Medicaid ID #**	

LEVEL OF SERVICE IS REQUIRED FOR BENEFICIARY & PRESCRIBED BY MEDICAL PROVIDER

(Check All That Apply Below)

☐ **Medivan (Door 2 Door Needed)**

Car/taxi/van (patient must have assistance to make it to the vehicle)

(If beneficiary utilizes wheelchair, check one below)

☐ **Wheelchair able to transfer**

Car/taxi/van (folding wheelchair unable to make it to the vehicle alone)

☐ **Wheelchair lift-equipped van transport**

☐ **Patient is unable to transfer from wheelchair**

Describe the specific medical condition(s) directly related to the reason the patient/beneficiary is unable to use public transportation. _____

_____

Medical Level of Service Criteria

(Check All That Apply Below)

☐ Walking difficulty	☐ O2 via trach requiring suctioning
☐ Uses cane/walker	☐ Travels with Oxygen
☐ Brings Escort	☐ Disoriented/Confused
☐ Requires assistance of trained personnel	☐ Risk of fall from chair/safety
☐ Confined to wheelchair	☐ Unable to bear weight
☐ Unrepaired / Recent Fracture / Joint Hip Replacement	

Estimated duration of the prescribed Level of Service is medically necessary for:

☐ **90 Days** ☐ **6 Months** ☐ **1 Year**

Knowingly providing false information on this Certification may constitute fraud and may prevent the beneficiary from receiving further transportation services. If you have any questions regarding clarity of the form, please contact LogistiCare at 866-569-1908.

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

Physician or Certified Professional: PRINTED NAME / TITLE: _____

SIGNATURE: _____ **DATE:** _____

******* This form can be completed by a Primary care physician (PCP), physician's assistant, physician specialist, nurse practitioner working under the supervision of the PCP, clinical nurse specialist, certified nurse midwife, registered nurse, social worker, dentist, and other licensed providers. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical, behavioral or dental services to the beneficiary.