MI Operations
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Southfield, MI 48033
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PHYSICIAN'S TRANSPORTATION RESTRICTION FORM

The purpose of this form is for a physician to communicate to LogistiCare specific transportation restrictions of a patient / Member due to a medical condition. The restrictions and requirements stated on this form will be used by LogistiCare to determine the best means of transportation for the patient / Member.

Today's Date: _____

Patient / Member Information:

Name: _____

Medicaid ID Number: _____ DOB: _____

Transportation Needs: *(Please check all that apply; must be completed by physician)*

- ☐ This appointment is for a Medicaid covered service and is medically necessary. The appointment is with the nearest appropriate Medicaid provider.
- ☐ Patient / Member is medically unable to walk ¼ mile.
- ☐ Patient / Member is medically unable to be driven by friend or family member.
- ☐ Patient / Member is medically able to use public transportation (e.g., bus or other public mass transit) ONLY if accompanied by an aide/companion. (If so, LogistiCare pays for the aide's/companion's fare, but LogistiCare does not provide the aide/companion.)
- ☐ Patient is Paratransit certified.
- ☐ Patient is unable to use public transportation because:
  _____
- ☐ Patient / Member can only be transported by stretcher and does not need/ is unlikely to need immediate medical attention during transportation.
  Medical Reason(s):_____
- ☐ Does patient / Member have a wheelchair*? Yes** / No Type: Manual / Electric / Scooter *(*LogistiCare does not provide wheelchairs or scooters.*)
  **Is patient / Member able to transfer without assistance? Yes / No Patient Member is able to sit up on his/her own.
- ☐ Patient /Member uses a cane/walker. How many feet can patient / Member walk using this equipment? _____

****Describe the specific medical condition(s) directly related to the patient's / Member's need for a higher level of service other than public transportation:**

_____

Please list the medical condition: _____

Please indicate the expected expiration date of restrictions: _____

Physician Information:

NAME: _____ **TELEPHONE:** _____

SIGNATURE OF PHYSICIAN: _____ **DATE:** _____