LogistiCare

Attn: Facilities Department
Fax: 877-457-3316 Phone: 866-527-9945

Closest Provider Certification

PLEASE PRINT OR TYPE ALL INFORMATION BELOW. **Date:* ______________________

Please fill out the following questions in order for us to authorize transportation services.

1) *Patient's Name:______________________*Phone #: _________________________

2) *Patient's State Medicaid ID#: ____________________________________*DOB: ____/____/_______

3) Patient's Pick up Address: ____*County___________
Street City Zip Code

4) Physician's Name: ____ *Phone #____________________

5) *Physician's Address: ____ *County___________
Street City Zip Code

6) *Name of HMO / DUAL _______________Caseworker: ______________________________

7) *Total one way mileage for trip: *Treatment (if specialist what type):

8) **(This question should be filled out by HMO or MACC personnel only)**
Is this the closest available provider for this treatment type? _______Yes _______No

If yes, please put a check next to the exemption that applies.

- ☐ On-going Oncology treatment
- ☐ Admission/Pre-Post Surgery
- ☐ Specialty Care Hospital (i.e. CHOP)
- ☐ On-going substance Abuse
- ☐ On-going Physical Therapy
- ☐ On-going Pain Management
- ☐ Dialysis
- ☐ Other

If Other Must Explain:

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_____________________________________ _______________________________________

Authorized Signature (HMO or MACC Personnel) Please Print Name and Title

********* *(Signature must be in blue ink; stamped signatures will not be accepted)* *********

Falsifying information on this document may be construed as fraud and may prevent the client from receiving further transportation services through our office. If you have any questions please contact above fax or phone number. All forms must be returned within 10 business days.

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Logisticare Employee (Print full name): _______ ______________________________ ☐ **NJ** ☐ **NV**