NJ Operations
PO Box 11647
New Brunswick, NJ 08906
Fax: 877-457-3316

MEDICAL PROVIDER CERTIFICATION FORM

The purpose of this form is for medical providers to communicate to LogistiCare specific transportation restrictions of patients / Members due to medical/cognitive condition(s). The restrictions and requirements declared by medical providers using this form will be used by LogistiCare to determine the best means of transportation for the patient / Member.

Patient / Member Information: **Today's Date: _____**

Printed Name: _____

Medicaid ID #: _____ DOB: _____

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

☐ Patient / Member is medically/cognitively **ABLE** to use **PUBLIC TRANSPORTATION** (e.g. bus or other public mass transit).

☐ Patient / Member is medically/cognitively **UNABLE** to walk ½ mile.

☐ Patient / Member is medically/cognitively **UNABLE** to be driven by friend or family member.

☐ Patient / Member is medically/cognitively **ABLE** to use public transportation **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 / Member is **UNABLE** to use public transportation.

If the patient / Member is UNABLE to use public transportation, please choose one transportation level of service appropriate for the patient / Member:

☐ Patient / Member is **AMBULATORY** – (curb to curb livery service; can walk without driver assistance).

☐ Patient / Member is **AMBULATORY/MAV** – (door through door assistance; able to walk with assistance from driver).

Patient / Member uses a **CANE/WALKER**. How many feet can patient walk using this equipment? _____

☐ Patient / Member requires a **WHEELCHAIR.*** Type: Manual / Electric / Scooter (please circle one)
*(*LogistiCare does not provide wheelchairs or scooters.*)

If patient / Member requires a wheelchair, provide: Height _____ Weight _____ Stairs (#) _____

☐ Patient / Member is able to stand/transfer without assistance.

☐ Patient / Member is able to stand/transfer with the assistance of one person.

☐ Patient / Member is able to sit up on his/her own.

****REQUIRED**** **Describe the specific medical/cognitive condition(s) directly related to the patient's / Member's need for a higher level of service other than public transportation:** *(Do not use any number codes and please print)*

_____

_____

Is the period of incapacity permanent? Yes / No. If not, expected expiration date of restrictions: _____

Medical Provider Information:
A medical provider is defined as a Physician, Physician's Assistant, Nurse Practitioner, or Registered Nurse who has provided direct medical care to the patient / Member.

PRINTED NAME: _____ **TITLE:** _____

TELEPHONE: _____ **FAX:** _____

SIGNATURE OF MEDICAL PROVIDER: _____ **DATE:** _____