NJ Operations
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NEW JERSEY NON-EMERGENCY TRANSPORTATION SERVICES
MEDICAL PROVIDER CERTIFICATION FORM
FOR SPECIALTY CARE TRANSPORTS (SCTU) ONLY

PLEASE FAX COMPLETED FORM TO: 877-457-3316

The purpose of this form is to identify if the patient meets the following criteria to make them eligible for the SCTU transportation services as defined by the OEMS Regulations (Section 8:41-10.2)

- Does the patient have a life-threatening illness or injury?
- Does the patient s condition require constant attendance and management of medically necessary supplies and services by a critical care nurse?

Note: Statements made by medical providers regarding patient transportation restrictions are subject to review by the New Jersey Medicaid Fraud Division of the Office of State Comptroller.

TO BE COMPLETED BY MEDICAL PROVIDER (PHYSICIAN, RN, PA, NP): *PLEASE PRINT*

Today's Date _____ Patient's Name _____

Medicaid ID Number _____ Patient's Date of Birth _____

CARE REQUIRED DURING TRANSPORT (please check all that apply):

☐ The patient requires continuous cardiac monitoring. (Not pulse ox)

☐ The patient requires continuous monitoring of an IV drip.

☐ The patient's condition requires constant attendance and management of medically necessary supplies and services by a critical care nurse.

☐ The patient requires deep tracheal suctioning.

☐ Requires transportation in a supine or prone position.

☐ The patient requires an automatic ventilator or ventilator assisted mode.

☐ Will the patient's home health provider be travelling with the patient? (If yes, they will be responsible for the management of the patient's equipment, i.e. ventilator, adjusting oxygen.)

☐ Other _____

IF THE PATIENT DOES NOT MEET ONE OR MORE OF THE ABOVE CRITERIA, PLEASE INDICATE THE CORRECT LEVEL OF SERVICE BELOW:

☐ Wheelchair/MAV – (door through door assistance and travels via manual or power wheelchair)

☐ BLS – (travels via stretcher, bed bound, and does not require advanced medical monitoring)

Does the patient require oxygen provided by the transportation provider? ☐ YES ☐ NO

Medical Provider (MD, RN, PA, NP) Name (please print)**:** _____

Medical Provider (MD, RN, PA, NP) phone number**:** _____

Medical Provider (MD, RN, PA, NP) fax number**:** _____

Date**:** _____ Medical Provider (MD, RN, PA, NP) Signature**:** _____

Physician/RN/ PA/ NP Comments**:** _____

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