UTAH PHYSICIAN'S CERTIFICATE

This certificate is for doctors to communicate to LogistiCare any specific transportation restrictions (mass transit, wheelchair / stretcher / ambulatory vehicle) of patients due to medical conditions. The restriction and requirements declared ONLY by a Doctor, Nursing Practitioner, or Physician Assistant will be used by LogistiCare to determine the best means of transporting this patient. These statements may be reported to State Medicaid who requires that this form be 100% completed to be valid. The patient will be offered ONLY four consecutive weeks of trips if this form is not completed or returned.

Today's Date: _____ Patient's Name: _____

Medicaid ID Number: _____ DOB: _____

Address: _____ Phone #: _____

Medical Professional's Name (Printed): _____

Office Phone: _____ Office FAX: _____

Office Mailing Address: _____

1: You are the Medical Provider who is aware of the above patient's mobility capabilities.
☐ Yes ☐ No If "No", please STOP and return form.

2: Does this patient have access to a household vehicle in order to travel to/from your office or other medical appointments? ☐ Yes ☐ No

3: If "Public Transportation" is available in the patients' area, do they have the physical ability to ride a bus and/or Para Transit (curbside service for wheelchairs or physical disabilities)?
Bus: ☐ Yes ☐ No Para-transit: ☐ Yes ☐ No

If "No" to either, provide medical reason: _____

_____

4: Does patient require an adult escort (who must be 18 years or older) for medical reasons (i.e. blind, minor, disability, mentally handicapped, non-verbal, etc.).
☐ Yes ☐ No If "Yes", please explain why: _____

_____

NOTE: If "Yes", all trips will require an escort until informed in writing by a physician that an escort is no longer needed.

5: Does the patient require stretcher transport? Will patient need medical attention during transportation (form is only valid for three (3) months) ☐ Yes ☐ No If "Yes", please explain: _____

_____

6: Does patient have a wheelchair? ☐ Yes ☐ No Type: ☐ Manual ☐ Electric (LogistiCare does not provide wheelchair)
Is patient able to transfer out of their wheelchair WITHOUT assistance? ☐ Yes ☐ No

7: For safety reasons, if they do use a wheelchair, what is the weight of the patient WITHOUT the wheelchair?
_____ pounds

8: Does patient use a mobility aid? ☐ Yes ☐ No Type: ☐ Cane ☐ Walker
How many yards can the patient walk independently using this equipment?_____

9: How far can the patient travel unaided?
Walking: ___300 ft or 100 yds ___600 ft or 200 yds ___900 ft or 300 yds ___more than1600 ft or 600 yds

10: Does the patient have any serious psychological, social or mental dysfunctional impairment that could affect their transportation services? ☐ Yes ☐ No If "Yes", please briefly explain and if under control:

_____
_____
_____

11: Patient is able to sign driver's log. ☐ Yes ☐ No If "No", please provide a Medical Reason(s):

_____

12: Is period of incapacity permanent? ☐ Yes ☐ No If No, expected expiration date of restrictions:

_____

14: Please provide any medical diagnosis to help LogistiCare determine the transport needs of the patient:

_____
_____
_____
_____

I certify that the information contained herein is true and accurate to the best of my medical judgment and knowledge.

_____ ☐ MD/DO ☐ PA ☐ NP/RN
Medical Professional's Signature

Please return this information as soon as possible to:

LogistiCare Solutions: Attn: Utilization Review Phone: 855-563-4401 FAX: 877-637-9079

Non-Emergency Medical Transportation for the Utah Medicaid Program