LogistiCare

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Medicaid & Medical Assistance

MASS TRANSIT RESTRICTION FORM

The patient is a Medicaid Member to whom you have provided direct medical care. The patient / Member has requested non-emergent medical transportation, and may possibly utilize public transportation (e.g., bus or other public mass transit) because he/she resides within ½ mile of a fixed route bus stop. Please evaluate the additional criteria listed below and indicate which factor(s) apply to this patient / Member. LogistiCare and the Department of Medicaid and Medical Assistance (DMMA) use this information to determine if public transportation is the most appropriate means of transport considering any medical condition the patient / Member may have.

Please remember that any statements you make regarding the patient's / Member's medical condition(s) and any transportation restrictions you suggest must be true, accurate and complete, under penalty of the laws governing Medicaid fraud. LogistiCare is required to verify the information you provide and report any irregularities or discrepancies to DMMA.

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

Name: _____

Medicaid ID #: _____ DOB: _____

This form may be completed by any Physician, Physician's Assistant, Nurse Practitioner, or Registered Nurse who has provided direct care for the patient / Member named above. Please check all that apply :

- ☐ Patient / Member is physically unable to walk ½ mile. **
- ☐ Patient / Member is physically unable to stand for short periods of time. **
- ☐ Patient / Member is unable to understand common signs and directions. **
- ☐ Patient / Member is pregnant or traveling with two (2) or more minor children.
- ☐ Patient / Member is physically 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 **physically unable** to use public transportation.

****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:**

_____

_____

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

I certify that the above information is true and correct based on my medical evaluation of the patient / Member named above, and represent that due to the medical condition(s) descibed, he/ she requires transport by the mode requested on this form. I understand that this information will be used by LogistiCare and the DMMA to support the determination of medical necessity for services provided, and that I have personal knowledge of the patient's / Member's medical condition at the time of transport.

NAME: _____**SIGNATURE:** _____**TITLE**_____

TELEPHONE #: _____ **FAX #:** _____

DATE: _____

Please fax form to 877-813-5599