LogistiCare

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

Date: _____

Re: _____
(Patient)

Dear Dr. _____,

Your patient has requested non-emergent medical transportation and it has been determined that they can possibly utilize public transportation as they reside within 0.5 miles of a fixed route bus stop. The criteria listed below are used to further determine if this is the most appropriate means of transportation in respect to any medical condition they may have.

Please be reminded that any statements made regarding your patient's transportation restrictions are made under penalty of Medicaid fraud. LogistiCare will verify this information and report any discrepancies to DMMA.

Please complete this form by checking categories that apply. Sign, date, and return this form to LogistiCare via fax 877-813-5599.

Thank you.

Patient: _____

DOB: _____ Medicaid No._____

_____Client is unable to ambulate 0.5 miles

_____Client is unable to stand for short periods of time

_____Client is pregnant

_____Client cannot understand common signs and directions

_____ None of the above

Physician: _____ Date: _____

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