REQUEST FOR TRANSPORTATION OUTSIDE THE COMMON MEDICAL MARKET AREA

The information provided below will assist the Medicaid program in determining the need for transportation outside the common medical market, i.e., the area where the community generally receives its medical care. Transportation may be authorized for a Medicaid enrollee when the appropriate Medicaid-covered treatment is unavailable locally. While this completed form is required, completion of this form does not guarantee authorization of Medicaid-funded transportation outside the common medical marketing area. The Medicaid program will not authorize transportation outside the common medical marketing area when the enrollee has been non-compliant with local medical providers and is unable to receive service locally based on their own actions.

Patient Name: ______________________________ **Patient Medicaid Number:** ________________________ **Patient Date of Birth:** __/__/______

1.) Please indicate whether you are the referring physician: ○ **YES /** ○ **NO** **2.) Is the medical service to which you are referring the enrollee available locally?** ○ **YES /** ○ **NO**

3.) If the services are available locally, please explain below why the services within the CMMA are inappropriate for this enrollee. ***Please note, to avoid a delay in transportation for the patient your response requires detailed information. For example, continuity of care without specific reasons why that care must happen outside the CMMA will result in an immediate denial.***

4.) Please indicate whether the referral is to see a specialist:______YES /______NO (if no please move to question 5). If yes, please answer the following questions.

4a.) To which specialty is the enrollee being referred?__________________________ **4b.) What is the specialists name?** ______________________________

4c.) What is the specialists service location?______________________________ **4d.) Do you believe that this referral will require multiple appointments:** ○ **YES /** ○ **NO**

5.) Is this referral for Primary Care, Mental Health, Physical Therapy, lab work or an Independent Medical Exam (IME)? ○ **YES /** ○ **NO**

Referring Physician:______________________________ ***10 digit NPI #:***____________________ ***Telephone Number:*** ____________________

Hospital/Clinic/Facility/Practitioner Name:______________________________ ***Hospital/Clinic/Facility/Practitioner Address:*** ______________________________

Name of Staff Member who helped complete this form:______________________________ ***Title:***____________________ ***Telephone Number:*** ____________________

Signature of Referring Physician:______________________________ ***Date Signed:*** ____________________

CERTIFICATION STATEMENT: *I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including 18 NYCRR § 504.8(a)(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.*

For guidance on completion of this form, please call ModivCare at 844-678-1104

Please Fax this form to 855-848-8642

New York State Department of Health 2020-U Form