Referral to another Medical Site Transportation Request Fax Form (3/5-2015)

Nassau and Suffolk County Medicaid Trip Order Form from One Medical Practitioner Referring an Enrollee to Second Medical Practitioner

Questions?: Contact the ModivCare Facility Services Department 844-678-1106

Trip Date: ____________ **Appointment Time:**____________ **Pick-Up Time:**_____:_______ **AM/PM** **Return Time:**_________**AM/PM**
(If return time is unknown, enter 23:59)

Preferred Transportation Provider: ____

□**Public Transit** □**Livery** □**Ambulette Ambulatory** □**Ambulette Wheelchair** □**Stretcher** □**BLS Ambulance** □**ALS Ambulance**

Enrollee Name:____Medicaid ID Number: ____________________

Enrollee Pick-up Address:____Phone Number:_______________

Destination Facility:__________________________________NPI#:_____________Phone Number:_______________

Address:____

Destination Physician's Name: ____________________________________

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 Regulation 504.8(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.

______________________________ ____________________ ______________ ____________________
Referring Physician's Name (PRINT) NPI# Date Telephone#

____
Name of the referring medical practice, hospital or clinic

____
Indicate name of nurse/social worker or other person whoassisted in completing this form

______________________________ ______________________________ ____________________
Referring Physician's Signature Referring Medical Practitioner's Address Telephone #

Fax three days prior to appointment –1-855-848-8640