**Nonemergency Medical Transportation (NEMT) Require Justification**

In order to appropriately evaluate your request, complete all form fields below including licensed provider signature and date of signature. If any field is incomplete, further documentation may be requested. This form constitutes a prescription. [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323 and the Medi-Cal Provider Manual]

| 1. Patient's Name ______________________ | 2. Medical I. D. Number ______________________ |
|---|---|

3. The current Skilled Nursing Facility (SNF) face sheet is:
   - attached, since this patient currently resides in a SNF.
   - not applicable, since this patient resides at home.

| 4. Dates of Service (DOS) From ____________ To ____________ | 5. Appointment Time Start ____________ End ____________ |
|---|---|

6. Day(s) of the week transported to above appointment(s)
   Monday Tuesday Wednesday Thursday Friday Saturday Sunday

7. Documentation is attached
   - attached, since transport is not to the nearest facility that can meet the patient's medical needs.
   - not applicable, as transport is to the nearest facility that can meet the patient's medical needs.

8. Diagnosis specific to visit(s)

9. Medical purpose/justification for visit(s)

10. The prescribed treatment plan including problems, interventions, and goals (along with why original goals were not met, if this is a reauthorization TAR)
    - is attached, since request is for multiple transports that are ongoing to same provider for same chronic diagnosis.
    - is not applicable, since request is for a single transport for a routine visit or one-time medical event.

**Nonemergency Medical Transportation (NEMT) Require Justification**

11. Patient mobilizes via:
    Wheelchair    Walker    Cane    Other (describe) ______________

12. Functional limitations, (specific physical or mental), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: (If more space is needed, please attach another page.)

13. Based on 11 and 12, above, the required mode of transport is:
    Wheelchair van    Gurney or litter van    Ambulance

| 14. Licensed Provider Specialty ________________________ | 15. License Number ________________________ |
| --- | --- |

16. Provider Address (number, street, city, zip code)
    Street ____________________________________________
    City ________________________________ Zip Code __________

| 17. Licensed Provider Name ______________________________ | 18. Telephone number (Area code and number) ______________________ |
| --- | --- |

| 19. Licensed Provider signature (No proxy, no stamps) | 20. Date ______________ |
| --- | --- |