MedRide

Non-Emergency Medical Transportation

NEMT-APPLICATION

NEMT will assist Medicaid recipients with non-emergency medical transportation to and from their medical doctor appointments. If the recipients have no other means of transportation, this service is a benefit provide by Colorado Medicaid.

The appropriate mode of transportation will be determined by your physician on (pg. 2)

All pages of this application must be **completed, signed and dated by your Primary Care Physician**, Physician's Assistant, Nurse Practitioner, Therapist or a licensed healthcare professional.
If you are being referred to receive care outside of your County, the form "Beyond 25 miles" (pg.3) is **required** to be completed by the physician that is referring you to seek medical care outside of the county. They also need to include the reason why you cannot receive care closer to your home.
The applicant is required to sign and date the attached **Declaration** (pg. 4) and return with the completed medical certification application.
Any missing or incomplete forms will **delay** the eligibility determination process; or may be denied.
You can submit the completed Medical Transportation Application by one of the following options:
Mail: 635 W Corona Ave Suite #213 Pueblo Co, 81007
Fax: (719) 545-0499
Email: Medridetransportation@gmail.com

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To be valid, the Attending physician, Physician's Assistant, Nurse Practitioner, Therapist or other licensed healthcare professional must complete and sign this certification. The least costly and most appropriate means of travel must be utilized.

Patient Name: ____ Patient Medicaid #____________

Patient Address: ____

Patient DOB: ____________________ Patient Contact #: ______________________

PLEASE CHECK ALL MEDICAL CONDITIONS BELOW THAT APPLY TO THIS PATIENT:

___ Unable to travel alone, needs service attendant ___ Bariatric Patient: Weight ___ Height___

___ Requires Oxygen that is self-administered ___ Pediatric Patient

___ Traveling with an ADA service animal

PLEASE SELECT WITCH MODE(S) OF TRANSPORATION THE PATIENT NEEDS:

___ Mileage Reimbursement

Does the patient own a Vehicle or have a friend, family member, volunteer who is willing to drive them to and from their medical appointments?

___ Privately contracted vehicle / Taxi Service

Does patient not own a Vehicle or have a friend, family member, or or volunteer who is willing to take them to appointments? Is the patient able to get into and out of the regular sedan style vehicle?

___ Non-Emergency Ambulance Service

This service cannot be selected solely for lifting needs without having any additional medical necessity present. Please check all that apply.

___ Potentially combative-dementia of behavioral

___ IV fluid administration and monitoring

___ Medication administration en-route

___ Advanced airway management including suctioning or vents

___ Oxygen administration by medical personnel

___ Medical supervision during transport

I affirm that the above statements are true and accurate to the best of my knowledge and federal funds will be used for the service I am requesting on behalf of my patient and the most medically appropriate service is being requested.

Name of licensed Medical Provider: ______________________ Signature of Medical Provider: ______________

Date Signed: ________________ Phone number of Provider: _________________

Certification expiration date: ________________ OR Expiry Date "INDEFINATE" __________________

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Medical Certificate of Transportation Services Beyond 25 Miles

To be valid, the Attending Physician, Physician's Assistant, Nurse Practitioner, Therapist or other licensed healthcare professional must fully complete and sign this certification form.

Patient Name: ____ **Patient Medicaid #**_____________

Patient Address: ____

Patient DOB: _____________________ **Patient Contact #:** _______________________

Medical Facility the patient is being referred to that is outside of the County:

Facility Name: ________________________ **Medical Provider's Name:**

____

Facility Address: ______________________ **Specialty:** ____

____________________________________ **Facility Phone #:** ___________________________________

____

Please explain why patient cannot be seen by a provider closer to the patient's home:

____

____

____

Agreement and signature:

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Name of licensed Medical Provider: ____

Signature of Medical Provider: ____

Date Signed: ______________________ **Phone number of Provider:** _________________

Certification expiration date: ________________ **OR** **Expiry Date "INDEFINATE"** _________________

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DECLARATION: I do not have any means of transportation that is of no cost to the state of Colorado. Without reimbursement from the State, I would not be able to attend medically necessary appointments. I understand the trip must be the most direct route to and from the appointment with the closest qualified provider.

I authorize release of medical information necessary to process this request.

Name: ______________________________________ DOB: ___________________

Address: ____________________________________

Medicaid ID: _________________________________

Signature: ___________________________________ Date: ____________________

This form must be signed by applicant/parent or guardian and returned to MedRide Transportation.

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Standing Order Trip – Request for Transportation Services

This form must be complete and legible to properly schedule transportation.

- Please note, Standing Order requests can only have up to **3 changes per month** made to them (i.e changing addresses, pick up days or times, etc.) **After 3 changes**, these requests are no longer considered Standing Orders and will need to be submitted as individual trips.

Order Status: _____ **New Order** _____ **Revision**

Patient Name ____________________________________ Patient Medicaid ID # _______________

Patient DOB ___________________________ Today's Date _______________________________

Agency/Hospital __________________________ Contact _________________________________

Contact Phone # ________________________ Fax # _____________________________________

Scheduling Information:

Pick Up Address:	**Drop Off Address:**
Address: _______________________________	**Address:** _________________________________
City: __________________________________	**City:** _____________________________________
Phone #: _______________________________	**Phone #:** _________________________________

Schedule Information:

Time of Appointment: ____

Start Date: ____

Days of Travel: ___ MON ___TUES ___WED ___ THURS ___ FRI ___ SAT ___ SUN

Trip Purpose: _____ Dialysis _____ Chemo _____ Radiation

Name of requesting person ____________________ **Signature** _________________________________

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MedRide's first and top priority is that our clients are satisfied with the services we provide regarding NEMT. Complaints can be sent to Medridetransportation@gmail.com and further investigation and actions will be taken once our investigation is complete.

Date:

____

Person making Inquiry: ____

Contact Phone: ____

Clients Name (if other then person making inquiry) ____

Clients Contact Phone: ____

Date of Incident: ____

Was MedRide Contacted: ____

Details of incident: ____

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