MedRide LLC.

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 "INDEFINITE"** ______________

Mailing Address: MedRide LLC.

635 W Corona Ave Suite #213 Pueblo Co, 81004

Phone: (719) 545-3333 Fax: (719) 545-0499