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 provided 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.
- 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: 6005 Delmonico Dr. Suite #200 Colorado Springs Co. 80919
  Fax: (719) 545-0499
  Email: Medridetransportation@gmail.com

MedRide Level of Service Form

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 TRANSPORTATION THE PATIENT NEEDS:

___ Privately Contracted Vehicle / Taxi Service

Does the patient not own a Vehicle or have a friend, family member, 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?

Diagnosis that supports transportation limitations (MUST PROVIDE)

_____

Does this patient require an escort for assistance during transportation because of:

Age - Minor Under 17 _____

Mental Wellness _____

Physical Aid _____

Does the patient use any of the following assistive devices?

_____ Cane _____ Crutches _____ Walker _____ Portable Oxygen _____ Service Animal _____ Electric Wheelchair _____Manual Wheelchair

Can Patient self-propel in a wheelchair? _____ Yes _____ No

Can Patient self-transfer from a wheelchair? _____ Yes _____ No

Facility Information

Facility Name: _____

County Facility Is In: _____

Medical Professional Printed Name: _____Phone #: _____

Medical Professional Signature: _____ NPI #: _____

*By signing, the medical professional certifies and attests that each statement is accurate and true to the best of their knowledge.

****Medride LLC shall not be responsible for the loss, damage or destruction of Employee's or Client's personal property while such property is within the Company's vehicles.**

Mailing Address: MedRide LLC.
6005 Delmonico Drive, Suite 200, Colorado Springs, CO 80919
Phone: (719) 545-3333 Fax: (719) 545-0499

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 #:** _____

MUST FILL OUT* Medical Facility the patient is being referred to that is outside of the County: *MUST FILL OUT

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

Facility Address: _____

Facility Phone #: _____ **Specialty:** _____

Date of Trip: _____ **Time of Trip:** _____

Frequency (If on going): ___**Mon** ___**Tue** ___**Wed** ___**Thu** ___**Fri** ___**Sat** ___**Sun**

Treatment end date:_____ **or "Indefinite":**_____

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

_____

_____

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: _____ **NPI #** _____

Date Signed:_____ **Phone number of Provider:**_____

Certification expiration date: _____ **OR** **Expiry Date "INDEFINITE"** _____

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