MedRide Form Instruction Sheet

Non-Emergency Medical Transportation

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 the Health First Colorado Medicaid Program.

The appropriate mode of transportation will be determined on pg. 2

- If the patient is being referred to receive care outside of their County, the segment that states **__Medical Certificate of Transportation for Services Beyond 25 miles__** is __required__ to be completed by the physician that is referring you to seek medical care outside of the county or the physician the patient is seeing that is outside of their residing county. The state of Colorado also requires the reason why the patient cannot receive care closer to their 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
Email: applications@medrideco.com
Fax: (719) 545-0499

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 DOB: _____ **Patient Contact #:** _____

Patient Address: _____

- **Diagnosis that supports transportation limitations (MUST PROVIDE)**

_____

- **Does the patient require a wheelchair accessible vehicle?** _____ **Yes** _____ **No**

Medical Certificate of Transportation for Services Beyond 25 Miles

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 Phone #: _____ **County Facility Is In:** _____

Facility Address: _____

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

Frequency (If ongoing): ___Mon ___Tue ___Wed ___Thu ___Fri ___Sat ___Sun

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

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

_____

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"** _____

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.

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