

JUSTIFICATION REQUIRED FOR NON EMERGENCY MEDICAL TRANSPORTATION

Patient's Name _____ Medical I.D. No: _____

The transportation you requested for the above Medi-Cal beneficiary cannot be approved nor can the transportation company be reimbursed until we have sufficient medical information in accordance with the state regulations found in Title 22, California Code of Regulations, Section 51323, which establishes the conditions under which non emergency medical transportation is a benefit of the Medi-Cal program. In order to appropriately evaluate your request, all of the following items must be completed including physician signature and date of signature.

Deadline for submitting information: **ASAP**

1. **Diagnosis specifically related to this visit and medical purpose of visit.**

2. **The specific physical or mental limitation(s) that preclude the patient's ability to ambulate without assistance or be transported by private or public conveyance.**

3. **The code for the mode of transportation: (a) Wheelchair Van (b) Gurney or Litter Van (c) Ambulance.**

(a) WHEELCHAIR VAN

4. **The medical justification for both frequency and duration of the trips requested.**

5. **The treatment plan, goals or expected outcomes of the prescribed visits. (Note: If this is a re-authorization TAR, please indicate why original goals were not reached and new goals if any.)**

6. **Other: What assistive devices are used: Wheelchair _____ Walker _____ Cane _____ Other _____**
Please explain why:

Physician's Signature: _____ Date : _____

Physician's Name: _____ Lic. No.: _____

Address: _____

Date(s) of Service _____

Tel #: _____

**IMPORTANT: MD'S SIGNATURE IS REQUIRED, NO SUBSTITUTION PLEASE. HAND OVER TO DRIVER OR
FAX BACK TO 209-475-0709.**

**VANTAGE TRANSPORTS, INC.
Office: (209) 4750708
Fax: (209) 4750709**