SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

Letter of Medical Necessity for Non-Emergency Stretcher Transportation

MEDICAID MEMBER INFORMATION

Name: _____ Trip Date: _____

Medicaid Number: _____ Date of Birth: _____ Age: _____

Nature of Appointment: _____

Have you verified that physician can accept a stretcher within 10 minutes of arrival? _____ YES _____ NO

The following criteria must be met and applicable to the condition of the member at the time stretcher services are provided (circle all that apply):

1. The Member is unable to get up from bed without assistance
2. The Member is unable to ambulate; and
3. The Member is unable to sit in a chair or wheelchair

Please describe the member's physical condition(s) that makes transportation by stretcher medically necessary (i.e. normal transportation would endanger the health of the Member) and describe the Member's general physical condition: _____

_____

_____

RN Signature (single trip only):_____

If member's condition is persistent, a physician may request certification for up to 90 days.
Explanation: _____

_____

Physician's Name (please print): _____

Physician's Phone Number: _____

Medicaid Provider ID: _____**(required)** ***I certify that the above information represents an accurate assessment of the member's medical condition(s). In addition, it is my professional medical opinion that this member requires transport by stretcher and should not be transported by any other means.***

Physician's Signature:_____ **Date:** _____

*Southeastrans, Inc. is the Non-Emergency Transportation Broker for the member referenced. The purpose of this form is to gather information to insure that the requested services being provided to the member is within the guidelines established by both Federal and State Medicaid Agencies. STATEMENTS ON THIS DOCUMENT ARE MADE UNDER THE PENALTY OF STATE AND FEDERAL MEDICAID FRAUD GUIDELINES. **Specifically, you should be aware that it is both a state and a federal crime for a medical provider to: make false statements in connection with services paid for through federal health care programs (42 U.S.C & 1320a-7b; O.C.G.A. & 16-8-3)**. Any discrepancies found will be reported to the appropriate State and Federal Medicaid Fraud Control Units.

PLEASE FAX COMPLETED FORM TO 404-581-5543

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