SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

To submit the Medical Referral Form:
678-510-1354 (Fax)
For questions/concerns:
1-855-325-7565 (Phone)

*The **Medical Referral Form** serves to confirm that the eligible Medicaid member indicated below is receiving services within reasonable proximity of their primary residence; that there are no facilities/physicians in the member's area that offer the same or similar services within the member's trade area (the member's trade area is the parish in which the recipient resides, and the contiguous parishes). After completion, the attending physician must sign and date the form attesting to the need for the member to be seen at the facility listed below.*

Medicaid Member's Information

Name:	DOB: ___/___/____	Medicaid ID:
Address:		
City:	State:	Zip:

Medical Provider's Information

Referring Physician:			Referring Physician Phone #:
Referred Physician:			Referred Physician Phone #:
Referred Physician/Facility:			Type of Facility:
Address:			
City:	State:	Zip:	Medicaid Provider #:

Medical Necessity for Transport

Date of Issue: ___/___/____ Effective From ___/___/____ To ___/___/____

Length of time care need: Temporary ☐ Yes ☐ No Months Estimated: _____

Permanent ☐ Yes ☐ No

Scope of Referral:

☐ This is the closest facility/physician that can service the member because the member has one or more of the following needs **(please explain)**:

- ☐ Skilled Service _____
- ☐ Behavior _____
- ☐ Treatment _____
- ☐ Other

☐ This member has a condition that prevents them from being treated by physician/facility.

☐ Other (explain):

_____

_____

_____

☐ I am unable to attest to the member's need to be serviced by the Physician/facility requested. There are Physicians/facilities that offer the same or similar services within reasonable proximity of the member's primary residence.

Physician Attestation and Signature/Date

This is to certify that I am a licensed physician and that in my professional judgment it is medically necessary for the above Medicaid member to travel to the above facility/physician for the reasons indicated. The above information is accurate and complete to the best of my knowledge. I understand that the information documented above will be used by Southeastrans and The Department of Health and Hospitals (DHH) to determine the need to receive Non-Emergency Medical Transportation outside of member's trade area.

Physician's Name (printed) _____

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Physician's Signature _____ Date ___/___/____