Provider Certification Statement (PCS)

For Non-Emergency Medical Transportation (NEMT)

In order to appropriately evaluate your request, **complete all form fields** below including **provider signature** and **date** of **signature**. If any field is incomplete, further documentation may be requested. **This form constitutes a prescription.** [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323, PHC Policy MCCP2016, APL 22-008 and the Medi-Cal Provider Manual]

1. Patients Name	2. Medi-Cal I.D. number

3. Dates of Service (DOS)

From: __________________ To: __________________

Please complete for the desired date range of NEMT justification. Not to exceed 12 months and dependent on member eligibility.

4. Patient mobilizes via: Wheelchair ☐ Walker ☐ Cane ☐ Other (describe):

5. Functional limitations, (specific *physical* or *mental*), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: *(If patient can utilize taxi, public transport or gas mileage reimbursement please indicate this here.)*

☐ Patient is wheelchair bound and unable to self-transfer ☐ Dialysis ☐ Other (describe):

6. Based on 4 and 5, above, the required mode of transport is:
   - ☐ Public Transport – Member is capable of utilizing local bus or para-transit system without assistance
   - ☐ Taxi – Member can get from their home to the vehicle and transfer without assistance
   - ☐ Wheelchair Van – Member must be transported by wheelchair because of disabling physical or mental limitation or is unable to self-transfer
   - ☐ Gurney Van – Member must be transported in a prone or supine position because member is incapable of sitting upright
   - ☐ Ambulance – Member's medical condition prevents the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)
   - ☐ Air Ambulance – Member's medical condition prevents the use of ground transport (describe):

7. Provider signature (Acceptable signatures: MD, DO, DPM, PA, NP, DDS, CNM, LM, Physical, Speech or Occupational Therapists, and Mental Health/Substance use disorder providers. Personal signature only. No proxy. No stamps) *I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.*	8. Date 9. Medi-Cal Certified? ☐ Yes ☐ No
10. Physician Name (print or type)	11. NPI number
12. Provider specialty (print or type)	13. Telephone number (With area code)
14. Provider address (number, street, city, zip code)	15. Fax Number (With area code)