



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, Partnership policy MPTP2501, APL 22-008 and the Medi-Cal Provider Manual]

1. Patients Name	2. Medi-Cal I.D. number
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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.
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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>I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.</i>	8. Date
	9. Medi-Cal Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No

10. Physician Name (print or type)	11. NPI number
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12. Provider specialty (print or type)	13. Telephone number (With area code)
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14. Provider address (number, street, city, zip code)	15. Fax Number (With area code)
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