



REFERRAL REQUEST FOR TRANSPORTATION SERVICES AND PHYSICIAN CERTIFICATION STATEMENT (PCS)

The Department of Health Care Services (DHCS) requires that a PCS form be used to process and determine the appropriate level of all Non-Emergency Medical Transportation (NEMT) services. **Please submit completed, signed forms to:**

Routine: 714-338-3153 **Retrospective: 714-338-3153** **Urgent: 714-571-2424**

Incomplete or inaccurate forms may cause delays and/or denials.

Patient Information:

First Name: _____ Last Name: _____ Date of Birth: _____

Medi-Cal Number/CIN#: _____

Home Board and Care ICF-DD SNF Other:

Prescribing Provider Information:

Provider's Full Name (Print): _____ Provider NPI: _____

Phone Number: _____ Fax Number: _____

Facility Name: _____ Fax Number: _____

Contact Name: _____ Contact Direct Phone Number: _____

NEMT — PRESCRIPTION, MEDICAL NECESSITY CRITERIA, PCS AND REQUIRED SIGNATURE

Disclaimer: CalOptima Health is required to authorize the lowest-cost type of NEMT services appropriate for the member's medical needs. Once the PCS is submitted, CalOptima Health cannot modify the authorization to a lower level without a new PCS form from the provider.

NEMT Vehicle Type

Ambulance Litter/Gurney Van Wheelchair Van Air Ambulance

NEMT Provider Name: _____ Provider NPI: _____

Phone Number: _____ Fax Number: _____

NEMT Anticipated Duration:

Start Date: _____ End Date: _____ Six Months 12 Months

Justification: Provide medical documentation of specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles. Diagnosis alone does not constitute medical necessity (state functional limitations):

Diagnosis: _____ ICD-10 Codes: _____

Condition contraindicates the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)

Member is incapable of sitting for the length of time needed to transport

Member must be transported by wheelchair and is unable to self-transfer or self-propel

Certification Statement: This form **must be signed** by the physician, physician assistant, nurse practitioner, certified nurse-midwife, physical therapist, speech therapist, occupational therapist, dentist, podiatrist, mental health or substance use disorder provider responsible for providing care to the member and responsible for determining medical necessity of transportation consistent with the scope of their practice.

Approver Signature (Required): _____ **Date:** _____

Printed Name of Approver (Required): _____

I certify that California Code of Regulations [CCR], Title 22, Section 51323 (c) (2) was used to determine medical necessity for the type of transportation requested.