CenCal HEALTH®
Local. Quality. Healthcare.

# PHYSICIAN CERTIFICATION FORM

## NON EMERGENCY MEDICAL TRANSPORTATION (NEMT) REQUIRED JUSTIFICATION

NEMT services require *Prior Authorization,* except when the NEMT service is medically necessary for a discharge to home or a SNF, or for a transfer to another facility. CenCal Health must review and approve NEMT services BEFORE the member schedules a pick-up with VTS. Incomplete or inaccurate forms may cause delays and/or denials. CenCal Health may take up to fourteen (14) calendar days to review and process NEMT requests. This PCS Form is not required for Non-Medical Transportation (NMT) services. Completed and signed forms must be promptly submitted to CenCal Health, Utilization Management (UM) Department via fax or uploaded securely through our Secure File Drop:

- CenCal Health UM Fax: **805-681-3071**
- CenCal Health's Secure File Drop Link: **https://transfer.cencalhealth.org/filedrop/hs**

**Patient Information:**

| First Name: | Last Name: | | Date of Birth: |
|---|---|---|---|
| CenCal Member ID #: | | | Phone Number: |
| Address: | | | Caregiver Name: |
| City: | State: | Zip: | Caregiver Phone Number: |

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

***NEMT PROVIDER CERTIFICATION, JUSTIFICATION & SIGNATURE REQUIRED***

**Disclaimer:** CenCal Health is required to authorize the lowest cost type of NEMT services that is adequate for the member's medical needs.

**NEMT Vehicle Type (please check one):**

| Ambulance:<br>☐ Basic Life Support (BLS)<br>☐ Advanced Life Support (ALS) | ☐ Litter/Gurney Van | ☐ Wheelchair Van | ☐ Air Ambulance |
|---|---|---|---|

**NEMT Anticipated Duration:**

| Start Date: | End Date: | ☐ 30 Days | ☐ Six (6) Months | ☐ 12 Months |
|---|---|---|---|---|

ICD-10 Code(s):

**Diagnosis:**

**Justification:** Provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles. Include medical, behavioral health, or the physical condition that prevents ordinary means of public transportation:

**Provider Information:**

Provider's Full Name (Print):

| Title: | | Provider NPI: |
|---|---|---|
| Phone Number: | Fax Number: | Email: |

**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. By my signature, I certify that medical necessity was used to determine the type of transport being requested.

| **Signature (Required):**<br>**X** | **Date:** |
|---|---|