

Physician Certification Statement (PCS)



for Non Emergency Medical Transportation (NEMT)

NEMT services require Prior Authorization. CenCal Health must review and approve NEMT services BEFORE the member schedules a pick-up with the Transportation Provider. Incomplete or inaccurate forms may cause delays and/or denials. 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://gateway.cencalhealth.org/form/hs>

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

THE FOLLOWING FIELDS ARE ALL REQUIRED

PATIENT INFORMATION:

Last Name: First Name: Date of Birth:
CenCal Health ID #: Phone Number:
Address: Caregiver Name:
Patient currently mobilizes via: Wheelchair Walker Cane Other (describe):

NEMT VEHICLE TYPE (PLEASE CHECK ONE):

Ambulance Transport: Basic Life Support Advanced Life Support Air Ambulance Specialty Care
Vehicle Type: Litter/Gurney Van Wheelchair Van

NEMT Anticipated Duration (Maximum Duration is 12 months)

Start Date: End Date:

Is this related to Major Organ Transplant: Yes No

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:

Email: Provider NPI:

Phone Number: Fax Number:

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: Date: