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 provider. 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.

Provider signature

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) ✓