Human Resources Administration
Medical Assistance Programs

LIVERY, AMBULETTE & NON-EMERGENCY AMBULANCE SERVICES
MEDICAID TRANSPORTATION PRIOR APPROVAL FORM

Patient Name _____ Date of Birth _____ Sex _____

Address _____

Medicaid No.: _____ Social Security Number _____-_____-_____

1. (a) List Diagnoses (PRINT): 1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

(b) Why do these diagnoses justify transportation other than Public Transportation? _____

_____

2. (a) Does the patient use a wheelchair, scooter or portable oxygen? ☐Yes ☐No

(b) Does the patient require personal assistance of another individual to enter or exit a building or vehicle? ☐Yes ☐No

(c) Does patient have a family member or home attendant traveling with him/her? ☐Yes ☐No

3. (a) Is the patient's departure/destination point within his/her CMMA? (see definition under the Certification Statement) ☐Yes ☐No

(b) If not, justify travel outside CMMA _____

_____

4. Respond to this question only if **Non-Emergency Ambulance** is requested.

(a) Does the patient require life-sustaining equipment during transport? ☐Yes ☐No

(b) Does the patient require monitoring by a certified emergency medical technician or paramedic during transport? ☐Yes ☐No

(c) Does the patient need to be transported in a reclining position for:

1) Medical reasons ☐ Yes ☐No 2) Psychiatric condition ☐Yes ☐No

(d) Does the patient require use of the vehicle's oxygen during transport? ☐Yes ☐No

5. Indicate the location and the mode of transportation ordered pursuant to the filing of this document. Consult the New York State Department of Health ordering guidelines for definition of each mode of travel.

(a) Location: ☐Travel is within the CMMA ☐Travel is outside the CMMA.

(b) Mode: ☐ LIVERY ☐AMBULETTE ☐ Non-Emergency AMBULANCE

6. This transportation authorization is from ____/_____/_____ to ____/_____/_____. (NOTE: An authorization may cover a one way trip; a six-month period for patients with acute conditions; or twelve months for patients with chronic conditions.

INSTRUCTIONS:

Updated form is required when authorization period expires or when change in patient's condition results in a higher level of transportation. Form must be retained in medical practitioner's place of business readily retrievable for audit purposes.

CERTIFICATION STATEMENT

I (or the entity) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State and other publications of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.

I (or the entity) understand that the Common Medical Market Area (CMMA), as defined by New York State Social Service Regulation 505.10(b)(5), means the geographic area from which a community customarily obtains its medical care and services. This area lies within a five-mile radius of the recipient's residence.

HRA does not intend to limit a recipient's freedom to choose any Medicaid practitioner in the New York City region. Recipients are allowed to receive care and services from any practitioner willing to provide care. However, HRA is not required to pay the transportation expenses of a recipient to accommodate one's free choice when the same medical service is available closer to one's residence. Internal medicine, general and family practice, OB/GYN, pediatric and psychiatric services are considered by HRA to be typically available to Medicaid recipients/patients within the CMMA. This listing is not deemed all-inclusive.

By ordering transportation services for Medicaid recipients/patients traveling outside the CMMA, I (or the entity) certify that the Medicaid recipient/patient requires specialized care not available within the recipient/patient's CMMA, or that failure to maintain the continuity of services with a particular medical provider, although other appropriate care is available to the recipient/patient within the CMMA, is essential to the recipient/patient's physical and mental health, or there is an imminent need to initiate ongoing medical services that may be available within the CMMA but for which there exists a waiting list to receive care.

_____	_____	_____	(___)_____- _____	_____
Physician's Name (PRINT)	Physician's Signature	Date	Telephone #	License #

_____	_____	_____
Hospital/Clinic/Inst. Name	Medical Practitioner's Address	MMIS ID#

Indicate name of nurse/social worker/other person assisting in completing this form.

_____	_____	(___)_____- _____
Name	Title	Telephone #