GGM INC. TRANSPORATION

Non-Emergency Medical Transportation
NEMT-APPLICATION

You must be a fully benefitted Medicaid recipient, and have no other means of transportation to and/or from Medicaid appointments. You must provide verification you attended each appointment, and the service is a benefit provided by Medicaid.

The mode of transportation must be the least costly, most medically appropriate option. NEMT modes of transportation are:

- Standard Vehicle
- Non emergency ambulance
- Gas reimbursement for private vehicle use

The appropriate mode of transportation is determined by your physician.

- Please sign and date the attached Declaration.
- The enclosed medical form must be completed, signed and dated by your Attending Physician, Physicians assistant, Nurse practitioner, Therapist or licensed healthcare professional. If you are needing care outside of Pueblo County the Provider Certification referral form must also be completed.
- All requested documentation must be received, all fields completed, signed and dated to determine eligibility.
- Mail completed applications to 648 S Union Ave Pueblo, CO. 81004; or fax to 719/544-4187; or email to goldengatemanor1@aol.com

Mailing Address: Golden Gate Manor Transportation
648 S Union Ave, Pueblo, CO 81004
Physical Address: Golden Gate Manor Transportation
648 S Union Ave, Pueblo CO 81004 (844-543-2525)
Goldengatemanor1@aol.com

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Medical Certificate of Transportation Services

To be valid, the Attending physician, Physician's Assistant, Nurse Practitioner, Therapist or other licensed healthcare professional must complete and sign this certification.The least costly most appropriate means of travel must be utilized.

Patient Name*_____Patient DOB*_____ Patient Medicaid Number*_____
Patient Address*_____ Patient phone number*_____

___Unable to travel alone, needs service attendant ___Bariatric patient- Weight_____Height____
___Requires Oxygen that is self-administered ___Pediatric patient
___Traveling with an ADA service animal

Please check all medical conditions below that may apply to this patient:

☐ Mileage Reimbursement Does the patient own a Vehicle or have a friend, family member,or volunteer who is willing to drive them to and from their medical appointments?	☐Privately contracted vehicle/Taxi Service Does patient not own a Vehicle or have a friend, family member, or volunteer who is willing to take them to appointments? Is the patient able to get into and out of a regular sedan style vehicle?

☐Non-Emergency Ambulance Service
This service cannot be selected solely for lifting needs without having any additional medical necessity present. Please check all that apply
☐Potentially combative-dementia of behavioral
☐IV fluid administration and monitoring
☐Medication administration en-route
☐Advanced airway management including suctioning or vents
☐Oxygen administration by medical personnel
☐Medical supervision during transport

I affirm that the above statements are true and accurate to the best of my knowledge and federal funds will be used for the service I am requesting on behalf of my patient and the most medically appropriate service is being requested.

Name of licensed medical provider:_____
Signature of Medical provider:_____
Phone number of Provider:_____
Expiration date:_____ **Expiry Date Indefinite** ☐

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648 S. UNION AVE
PUEBLO, CO 81004
844.543.2525 (OFFICE)
719.544.4187 (FAX)

GOLDEN GATE MANOR, INC

MEDICAID TRANSPORTATION

FAX

If client will be traveling beyond 25 miles to your office or to a specialists office please complete and return the following form as well.

Thank You

GGM INC. TRANSPORATION

Medical Certificate of Transportation Services beyond 25 Miles

This form must be completed by a medical provider for accurate processing of this request.

Patient Name_____ Date DOB_____
Patient address_____
Patient Medicaid ID number_____Patient Phone number_____

Medical Facility Information:

Medical Providers Name:_____ Facility Name_____

Facility Contact person:_____ Phone:_____ Fax:_____

Facility Address:_____ Specialty:_____

City:_____ State:_____ Zip:_____

Explain why patient cannot be seen by a provider closer to the patients home:

Agreement and signature:
I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Medical Provider name:_____ Title:_____

Medical Provider signature:_____ Date:_____

Expiration date:_____ Expiry Date Indefinite ☐

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Medicaid Transportation Request

DECLARATION: I do not have any means of transportation that is of no cost to the State of Colorado. Without reimbursement from the State, I would not be able to attend medically necessary appointments. I understand the trip must be the most direct route to and from the appointment with the closest qualified provider.

I authorize release of medical information necessary to process this request.

Name:_____ DOB: _____

Address_____

Medicaid ID: _____

Signature: _____ Date: _____

This form must be signed by applicant/parent or guardian and returned to Medicaid Transportation.

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