GGM INC. TRANSPORTATION

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, Physician's 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

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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, needs service attendant
__ Requires oxygen that is self-administered
__ Traveling with an ADA service animal
__ Bariatric patient: WT: ____ HT: ____
__ Pediatric patient

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 the patient not own a Vehicle or have a friend, family member, or volunteer who is willing to take them to an appointment? Is the patient able to get into and out of a regular sedan style vehicle? Y __ N __

☐ 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 behavior
- ☐ 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. I also acknowledge 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: _____

- Expire Date Indefinite Expiration date: _____

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Medical Certificate of Transportation Services beyond 25 Miles

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

Patient Name*_____ Patient DOB*_____
Patient Address*_____
Patient Phone Number*_____ Patient Med ID #*_____

Medical Facility Information:

Medical Provider Name: _____
Facility Name: _____
Facility Contact person: _____Phone: _____Fax: _____
Facility Address: _____
City: _____ State: _____ Zip: _____
Specialty: _____

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

Agreement and signature:
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. I understand that if I have given false information or intentionally failed to disclose information, I may be subject to criminal or civil prosecution.

Medical Provider Name: _____ Title:_____

Medical Provider Signature: _____ Date: _____

- Expire Date Indefinite Expiration date: _____

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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 the release of the medical information necessary to process this request.

Patient Name*_____ DOB*_____

Patient Address*_____

Patient Phone Number*_____ Patient Medicaid Number*_____

Patient Signature: _____ Date: _____

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