NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Form 2015 (03/18)

VERIFICATION OF MEDICAID TRANSPORTATION ABILITIES

Enrollee's Name: _____ **Enrollee Date of Birth** __/__/____ **Enrollee Client ID Number:** _____

Enrollee's Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

1. What mode of transportation does this enrollee use for activities of daily living such as attending school, worship, and shopping? _____
2. Can the enrollee utilize mass/public transportation? ☐ Yes ☐ No. *If Yes, please proceed to the Medical Provider Information section of this Form.*
3. Does the enrollee have any medically documented reason that he/she cannot be transported in a group ride capacity? ☐ Yes ☐ No

   If you checked Yes, please provide a medical justification in the box on page 2.

4. Please **check** one box below for the mode of transportation you deem most medically appropriate for this enrollee:

☐ **Taxi:** The enrollee can get to the curb, board and exit the vehicle unassisted, or is a collapsible wheelchair user who can approach the vehicle and transfer without assistance, but cannot utilize public transportation.

☐ **Ambulette Ambulatory:** The enrollee can walk, **but** requires door through door assistance.

☐ **Ambulette Wheelchair:** The enrollee uses a wheelchair that requires a lift-equipped or a roll-up wheelchair vehicle **and** requires door through door assistance.

☐ **Stretcher Van:** The enrollee is confined to a bed, cannot sit in a wheelchair, **but does not** require medical attention/monitoring during transport.

☐ **BLS Ambulance:** The enrollee is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient.

☐ **ALS Ambulance:** The enrollee is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring and tracheotomy.

5. Is the above Mode of Transportation required for (check all that apply):
   - the enrollee's behavioral, emotional and/or mental health diagnosis? ☐ Yes ☐ No
   - for a mobility related issue? ☐ Yes ☐ No
   - required due to another health-related reason? ☐ Yes ☐ No
   - required due to unique circumstances that may impact a medical transportation request (*This may include but is not limited to circumstances such as: bariatric requirements, unique housing situations, and requirements for an escort, etc.*)? ☐ Yes ☐ No

If you answered Yes to any part of question 5 **or** selected a higher mode of transportation than what the enrollee uses for normal daily activities please proceed to number 6.

Fax to: (315)299-2786 **Form must be completed in its entirety or it will not be processed or approved** **For questions please call (866)371-3881**

Enrollee Name: _____Enrollee Date of Birth: _____Enrollee Client ID Number: _____

6. Enter **all** relevant medical, mental health or physical conditions and/or limitations that impact the required mode of transportation for this enrollee in the box below. Please include the level of assistance the enrollee needs with ambulation. (Example – enrollee requires 2-person assistance or enrollee requires 1-person assistance). If you answered Yes to question 3 or any part of question 5, it is important you provide as much detail as possible as to why you believe the enrollee's medical condition aligns with the requested mode of transportation. Insufficient details may cause the Form-2015 to be rejected and may lengthen the time it takes to get the enrollee approved for the higher mode of transportation.

Please indicate below the anticipated length of time this enrollee will require a higher mode of transportation:

☐ Temporarily until __/__/____ ☐ Long Term (9-12 months) until __/__/____ ☐ Permanent (subject to periodic review)

CERTIFICATION STATEMENT: *I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) 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, Provider Manuals and other official bulletins of the Department, including 18 NYCRR § 504.8(a)(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 making the request) 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.*

Medical Provider Information

Medical Provider's Name: _____NPI #: _____Date of Request: _____

Clinic/Facility/Office Name: _____Telephone #: _____Fax #: _____

Clinic/Facility/Office Address: _____City: _____State: _____Zip: _____

Name of person completing this form (Print): _____Title: _____

Name of Medical Provider attesting that all the information on this for is true (Print): _____

Signature of Medical Provider: _____Date: _____

Fax to: (315)299-2786 Form must be completed in its entirety or it will not be processed or approved For questions please call (866)371-3881