LIVERY-TAXI/AMBULETTE/AMBULANCE
NON-EMERGENCY TRANSPORTATION SERVICES
FAX TO:
TRANSPORTATION DEPARTMENT
FAX#: (716) 564-6250
TEL#: 1-888-FIDELIS (1-888-343-3547)

Member Name *(Last, First, M.I.):*		**DOB:**
Fidelis I.D:		
Medicaid Number:		**Social Security Number:**
Telephone Number:		
Primary Care or Specialist Section:	Provider Name:	Tax ID Number:
	Provider's Specialty:	Site Location:
	Telephone Number:	Fax Number:

MEDICAL JUSTIFICATION

List any current medical diagnoses:

Why do the diagnoses justify the requested method of transportation?

Please indicate the mode of transportation requested (Please note that clinical information must justify this request).
☐ **Livery/Taxi** ☐ **Ambulette** ☐ **Ambulance**

***Authorization, if approved, will only be provided for the dates and times requested. Maximum three (3) dates per Request Form. An updated form will be required for any additional appointments or when the member's condition results in a change of transportation mode.**

Provider Name	Provider's Address	Date of Appointment

Name *(Last, First, M.I.):*	Fidelis ID:

For acute and chronic conditions only, authorization may be requested to cover up to a three month date range.	FROM:	TO:

CERTIFICATION STATEMENT:

I (or the entity) understand that orders for Fidelis 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 Fidelis and/or 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 any 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.

Fidelis does not intend to limit a Member's freedom to choose any Fidelis Medicaid provider in the State of New York. Fidelis Member's are allowed to receive care and services from any practitioner willing to provide care. However, Fidelis is not required to pay the transportation expenses of a member to accommodate one's choice when the same medical service is available closer to one's residence. By ordering transportation services for Fidelis Medicaid Members traveling outside the county or neighboring county of where the Member resides, I (or the entity) certify that the Fidelis Medicaid Member requires specialized care not available within the specified area.

This request may be reviewed by a member of the Quality Healthcare Management staff. Please be advised that an incomplete request form will delay the approval process. All sections must be filled out completely to proceed to the review and approval process. **Once received allow 3 business days for authorization.**

Dear Provider: To avoid delays in the provision of transportation services please ensure that the box below is checked, signed and dated.

☐ **I have personally reviewed the certification statement and the medical information contained in this form and it is true, correct and complete to the best of my knowledge.**

Please print Provider's full name:	Provider's Signature:	Date: