



## NONEMERGENCY MEDICAL TRANSPORTATION (NEMT) REQUIRED JUSTIFICATION

In order to appropriately evaluate your request, **complete all form fields** below including **physician signature** and **date of signature**. If any field is incomplete, further documentation may be requested. **This form constitutes a prescription.** [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323 and the Medi-Cal Provider Manual]

1. Patient's name	2. Medi-Cal I.D. number
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3. The current Skilled Nursing Facility (SNF) face sheet is:

attached, since this patient currently resides in a SNF.  
 not applicable, since this patient resides at home.

4. Dates of Service (DOS) From: _____ To: _____	5. Appointment time Start: _____ <input type="checkbox"/> am <input type="checkbox"/> pm End: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
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6. Days(s) of the week transported to above appointment(s)

Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

7. Documentation is attached

attached, since transport *is not to the nearest* facility that can meet the patient's medical needs.  
 not applicable, as transport is to the nearest facility that can meet the patient's medical needs.

8. Diagnosis specific to visit(s)

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9. Medical purpose/justification for visit(s)

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10. The prescribed treatment plan including problems, interventions, and goals (along with why original goals were not met, if this is a reauthorization TAR)

is attached, since request is for *multiple* transports that are *ongoing to same provider for same chronic diagnosis*.  
 is not applicable, since request is for a single transport for a routine visit or one-time medical event.

11. Patient mobilizes via:

Wheelchair  Walker  Cane  Other (describe): \_\_\_\_\_

12. Functional limitations, (specific *physical or mental*), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: *(If more space is needed, please attach another page.)*

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13. Based on 11 and 12, above, the required mode of transport is:

Wheelchair van  Gurney or litter van  Ambulance

14. Physician signature (Physician's personal signature only. No proxy. No stamps.)	15. Date
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16. Physician specialty (print or type)	17. License number
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18. Physician name (print or type)	19. Telephone number (Area code and number) (     )
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20. Physician address (number, street, city, zip code)

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