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| **REFERRAL REQUEST FOR TRANSPORTATION SERVICES AND**  **PHYSICIAN CERTIFICATION STATEMENT (PCS)** | | | | |
| The Department of Health Care Services (DHCS) requires a PCS form to process and determine the appropriate level of all Non-Emergency Medical Transportation (NEMT) services. **Please submit this completed and signed form to:**  **Fax to 855-867-0868 or Website submissions to:** [**https://eznet.rchsd.org**](https://eznet.rchsd.org)  **Routine  Retrospective  Urgent**  Incomplete or inaccurate forms may cause delays and/or denials. | | | | |
| **Patient Information:** | | | | |
| First Name: | Last Name: | | Date of Birth: | |
| CIN#: | Address: | | | |
| **Prescribing Provider Information:** | | | | |
| Provider’s Full Name: | | Provider NPI: | | |
| Phone Number: | | Fax Number: | | |
| Name of Person Submitting: | | Phone Number: | | |
| **NEMT — PRESCRIPTION, MEDICAL NECESSITY CRITERIA, PCS AND REQUIRED SIGNATURE** | | | | |
| Disclaimer: CHOC Health Alliance must authorize the lowest-cost NEMT services appropriate for the member’s medical needs. Once the PCS is submitted, CHOC Health Alliance cannot modify the authorization to a lower level without a new PCS form from the provider. | | | | |
| **NEMT Vehicle Type:**  Ambulance  Litter/Gurney Van  Wheelchair Van  Air Ambulance | | | | |
| NEMT Provider Name: | | Provider NPI: | | |
| Phone Number: | | Fax Number: | | |
| **NEMT Anticipated Duration:** | | | | |
| Dates of Service (Maximum 6-month requested period) | | Start Date: | | End Date: |
| **Justification:** Provide medical documentation of specific physical and medical limitations that preclude the member’s ability to reasonably ambulate without assistance or be transported by public or private vehicles. *Diagnosis alone does not constitute medical necessity* (state functional limitations):  Diagnosis: ICD-10 Codes: | | | | |
| **Supporting Documentation Attached**:  Yes \*  NO \*Referral cannot be processed without supporting documentation. | | | | |
| Condition contraindicates the use of other forms of medical transportation (Member requires specialized equipment and/or personnel). | | | | |
| Member is incapable of sitting for the time needed for transport. | | | | |
| Member must be transported by wheelchair and cannot self-transfer or self-propel. | | | | |
| **Certification Statement:** This form **must be signed** by the physician, physician assistant, nurse practitioner, certified nurse-midwife, physical therapist, speech therapist, occupational therapist, dentist, podiatrist, or mental health or substance use disorder provider responsible for providing care to the member and responsible for determining the medical necessity of transportation consistent with the scope of their practice.  **Approver Signature (Required): Date:**  **Printed Name of Approver (Required):**  I certify that California Code of Regulations [CCR], Title 22, Section 51323 (c) (2) was used to determine medical necessity for the type of transportation requested. | | | | |