UTAH PHYSICIAN'S CERTIFICATE

This is a REQUIRED form that only Doctors, Nurse Practitioners or Physician Assistants must fill out to assist ModivCare to determine any specific transportation restrictions for patients due to medical conditions. **These statements will be reported to State DOH Medicaid who requires that this form be 100% completed to be valid.** The patient will be offered ONLY four consecutive weeks of trips if this form is not completed or returned.

****FILL OUT TOP PART COMPLETELY*** OR IT WILL BE DENIED**

Today's Date:_____ Patient's Name:_____

Medicaid ID Number:_____ DOB:_____ Phone #: _____

Patient's Address: _____

1: You are the Medical Provider who is aware of the above patient's mobility capabilities.
Yes No If **"No",** please **STOP** and return form.

2: Is the member able to use an available vehicle or can the member be transported via a family member or friend?
Yes No

3: Does the patient have the physical ability to safely get to, wait for and ride a bus or Para Transit even during the pandemic and extreme weather conditions (Snow, Heat) Yes Distance able to walk _____ No ☐

4: Does the patient require a companion (17 years or older) for medical assistance like (i.e. blind, minor, disability, mentally handicapped, non-verbal, etc.). Yes No If **"Yes",** please explain: _____

NOTE: If **"Yes",** all trips will require an escort until informed in writing by a physician that an escort is no longer needed.

5: Does patient use any of the following mobility aids? Yes No _____
Cane Walker Manual Wheelchair (W/C) Electric W/C Make/Model_____
***Weight of the patient without the wheelchair?** **Pounds.**

6: Does the patient have any serious psychological, social or mental dysfunctional impairment that could affect their transportation services or require a travel companion? Yes No If **"Yes"**, please explain: _____

7: Is period of incapacity permanent? Yes No If **"No"**, expected expiration date of restrictions: _____

8: Does the patient require stretcher transport? (Valid for only three (3) months) Yes No
If **"Yes"**, please explain: _____
(ModivCare does not provide any kind of medical aid, support or equipment)

I certify that the information contained herein is true and accurate to the best of my medical judgment and knowledge.

Medical Professional's Name (Printed): _____
Title: MD/DO PA NP/RN Signature_____
Office Phone: _____ **Office FAX:** _____

Please return this information as soon as possible to:

ModivCare Solutions: Attn: Utilization Review Phone: 855-563-4401 FAX: 877-637-9079
Non-Emergency Medical Transportation for the Utah Dept. of Health Medicaid Program