PROVIDER CERTIFICATION OF MEDICAL NECESSITY (MNF) FORM FOR TRANSPORTATION/MILEAGE REIMBURSEMENT FOR OVER 120 MILES

FAX to ModivCare: (866) 402-0522
PHONE: (866) 400-8233
TTY: (866) 288-3133

MEMBER INFORMATION			MEDICAL PROVIDER INFORMATION		
Date of Birth: _____/_____/_____	Sex: ☐ M ☐ F	Age:	Member ID#:	Medicaid #:	Phone #:
Patient/Member Name (Last, First, MI):			Referring Medical Provider Name and Address:		
Medical Provider Name and Address:			**If transportation is NOT medically necessary, please fill out this box and return the form by fax to (866) 402-0522.** _____**Transportation is not medically necessary.*** **Date:** ___________________ **Signature:** ____________________________________ * Pursuant to NMAC Regulation 8.310.2.12(L)(12)(b), if transportation is not medically necessary, the member will not be able to schedule the trip.		
If transportation is medically necessary, please continue filling out this form below.					

REQUIRED BY MEMBER AND APPROVED BY MEDICAL PROVIDER
Medically Necessary ☐ 120 Miles
Please provide justification of medical necessity for transportation for over 120 miles outside of the home community. Summarize member's medical history, including physical exams, laboratory results, and prescriptions, establishing the medical necessity for the prescribed level of service. (Additional documentation may be attached if necessary.) ____________________ ____________________ ____________________ ____________________ Estimated duration of level of service (check one): ☐12 Months ☐ Other:

This certification may be completed and signed only by the member's attending physician, physician assistant, or certified nurse practitioner to confirm a medically necessary level of service.

Knowingly providing false information on this certification may constitute fraud and may prevent the patient/member from receiving further transportation services. If you have any questions, please contact ModivCare's Facility Assistance Department at **(866) 400-8233.**

I certify that to the best of my knowledge, the above information is true, accurate, and complete and the level of service required for the patient's/member's transport is medically necessary for the patient's/member's health.

NAME: ____________________________ **SIGNATURE:** __________________________ **DATE:** _____________

Fax completed form to: (866) 402-0522

Mail completed form to:
(If mailing, please allow 7-10 days for processing.)

Facility Department
2602 S. 47th Street, Suite 100
Phoenix, AZ 85034