modivcare

UTAH PHYSICIAN'S CERTIFICATE

This is a REQUIRED form that only Doctors, Nurse Practitioners, Physician Assistants, Doctors of Physical Therapy, or Registered Nurses 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 DHHS 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.

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

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

Patient's Address: _____

Hierarchy of NEMT: Mileage Reimbursement, UTA/Cedar Area bus, Paratransit/CATS Dial-A-Ride, Modivcare, State (ambulance)

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 during extreme weather conditions (Snow, Heat) ☐ Yes: Distance able to walk _____ ☐ No

4: Does the patient require a companion (18 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: Is the patient able to safely ambulate/transfer to the vehicle? ☐ Yes ☐ No
If **Yes**: Does the patient need/require any mobility device? ☐ Cane ☐ Walker ☐ Leg Scooter
☐ Manual Wheelchair (W/C) ☐ Electric W/C Make/Model _____
If **NO**: Does the member require a mobility/WC vehicle? ☐ Yes ☐ No
If **YES**: ☐ Manual W/C ☐ Electric W/C? Weight of the patient w/o the W/C _____

6: Does the patient have any serious psychological, social or mental dysfunctional impairment that could affect their transportation services and 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/DPT** ☐ **PA** ☐ **NP/RN** **Signature** _____

Office Phone: _____ **Office FAX:** _____

Please return this information as soon as possible to:

ModivCare: Attn: Exceptions Dept **Phone: 855-563-4405 FAX: 877-637-9079**

Non-Emergency Medical Transportation for the Utah DHHS Medicaid Program

updated 2.04.2025