Form 2015-U (3/2013) **VERIFICATION OF MEDICAID TRANSPORTATION ABILITIES** **NYS DEPARTMENT OF HEALTH**

Patient Name	Patient Date of Birth	Patient Medicaid Identification Number

Patient Address	Patient Telephone #

1. In the left column below, please **check** the medically necessary mode of transportation you deem appropriate for this patient:

	Taxi	The patient can walk to the curb, board and exit the vehicle unassisted, **but** cannot utilize mass transportation.
	Ambulette/Ambulatory	The patient can walk **but** requires driver assistance.
	Ambulette/Wheelchair	The patient is a wheelchair user, requires a lift-equipped or roll-up wheelchair vehicle **and** driver assistance.
	Stretcher Van	The patient is confined to bed, cannot sit in a wheelchair, **and does not** require medical attention/monitoring during transport.
	BLS Ambulance	The patient is confined to bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered by patient, sedated patient.
	ALS Ambulance	The patient is confined to bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring, tracheotomy.

2**.** Using the space below, please **justify the mode** of transportation checked above:

3. Is the requested mode of transport **a long term** or **temporary** need of the patient? ☐ Long Term ☐ Temporary (for ___ months).

Physician's Name (PRINT)	NPI #	Telephone #

Hospital/Clinic/Facility/Practitioner Name	Hospital/Clinic/Facility/Practitioner Address

Name of the staff member who helped complete this form	Title	Telephone #

Signature of physician completing this form _____

DATE THIS FORM WAS COMPLETED_____

CERTIFICATION STATEMENT: *I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.*

Fax completed form to (315) 299-2786/(315) 299-2723
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