# REQUEST FOR TRANSPORTATION OUTSIDE THE COMMON MEDICAL MARKETING AREA

The information provided below will assist the Medicaid program in determining the need for transportation outside the common medical market, i.e., the area where the community generally receives its medical care. Transportation may be authorized for a Medicaid enrollee when the appropriate Medicaid-covered treatment is unavailable locally per NYCRR Title 18 §505.10, §360, 92 ADM 21, and/or review by representatives of the NYS Department of Health and/or its agents. While this completed form is required, completion of this form does not guarantee authorization of Medicaid-funded transportation outside the common medical marketing area. The Medicaid program will not authorize transportation outside the common medical marketing area when the enrollee has been non-compliant with local medical providers and that enrollee is unable to receive services locally based on their own actions. For guidance on completion of this form, please call the Health Department's transportation manager, Medical Answering Services, at (844) 666-6270.

| Patient Name | Patient Date of Birth | Patient Medicaid Identification Number |
|---|---|---|
| | | |

1. In the right column, please indicate whether you are the referring physician.
   *(If yes, please move to question 2.)* — YES / NO

2. In the right column, please indicate whether the medical services to which you are referring the enrollee available are available locally.
   *(If yes, please move to question 3.)* — YES / NO

3. If the services are available locally, please explain below why the local services are inappropriate for this enrollee.

4. In the right column, please indicate whether the referral is to see a specialist.
   *(If no, move to question 5. If yes, please answer the following questions.)* — YES / NO

   4a. To which specialty is the enrollee being referred? _____

   4b. What is the specialist's name? _____

   4c. What is the specialist's service location? _____

   4d. In the right column, please indicate whether this referral will require multiple appointments. — YES / NO

5. Is this referral for Primary Care, Mental Health, Physical Therapy, lab work, or IME?
   *(If yes, please move to question 6.)* — YES / NO

6. If the appointment is for Primary Care, Mental Health, Physical Therapy, lab work, or IME, please explain why the services must be sought outside the local area.

| Referring 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 referring physician _____

**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**