Medical Answering Services, LLC

The Dispatch & Authorizing Agency for Medicaid Transportation

Phone 866.244.8995 **P.O. Box 11998 Syracuse, New York 13218** **Fax 315.475.8123**

Out of County Transportation Form

The information provided will assist us in making an informed decision to determine the need for travel out of county. Transportation requests are for Medicaid billable services only. Out of County Transportation may not be authorized for a person that has been noncompliant with local medical providers and that person is no longer able to see a local provider due to their own actions.

A medical provider who is referring the Medicaid recipient for out of county medical treatment must completely fill out this form.

Patient's Name:____

CIN/Medicaid #:____________________ DOB____/____/______

Address:___________________________ City:_______________________State: _______Zip:__________

Are you the referring Physician?_______ If so, Name:___________________________________ If not, who is?_______________ _______________Phone #:__________________________Fax#:______________________

Is the appointment for Primary Care doctor, Mental Health, physical therapy, lab work, IME?_______________________________

Is the appointment to see a Specialist?_________ If so, what kind?____

Are the services available locally for the patient?____

If yes, why does the patient need to travel out of county?____

____

What are the services that cannot be rendered locally?____

____

Doctor and address patient is being referred to____

What medical reason patient is being referred to OOC doctor ____

Will these services require multiple appointments out of county?____

If yes, what are the approximate number of trips and length of treatment expected to be required?___________________________

____

What insurance are you billing for this Patient?____

Is the appointment for Workers Compensation, Liability, or SSI?____

Does patient have a vehicle?______________________________________

Out of County Transportation or reimbursement of transportation expenses may be approved for a Medicaid Recipient when the appropriate treatment is not available locally according to NYS Code, rules and regulations including but not limited to NYS NYCRR Title 18 Section 505.10, NYS NYCRR Title 18 Section 360, 92 ADM 21 and/or, review by local official or NYSDOH. A completed Verification of Transportation Abilities Form may also be required.

Provider Name:_____________________ Title/Degree_______________ NPI________________

Office #:___________________________________Fax#:____

Provider Signature____Date____/____/______

Filling out this form does not guarantee approval for Medicaid transportation out of county.

Return completed forms to
Medical Answering Services, LLC
PO 11998 Syracuse NY 13218
Fax: 315.475.8123

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