WVCH HEALTHCARE PROVIDER CERTIFICATION

This certificate is for Healthcare Providers to communicate to LogistiCare any specific transportation restrictions (mass transit, wheelchair / stretcher / ambulatory vehicle) patients may have due to their medical condition. The restrictions and requirements declared by the Healthcare Provider will **ONLY** be used by LogistiCare to determine the best mode of transportation for the patient in question. These statements may be reported to the Plan so this form must be **100% complete to be valid.**

Today's Date: ___________ Patient's Name: ______________________________________ Medicaid ID Number:____________________

Address: ____ DOB: ________________________

Physician/Healthcare Provider's Name (Printed): ______________________ Office Phone: __________________ Office FAX: ____________

1: You are the Healthcare Provider and are aware of and able to speak to the patient's mobility capabilities. Yes No

If "No", please STOP and return form

2: If "Public Transportation" (i.e.: Bus, Paratransit) service is available in the patient's area, is the patient able to board and use this service? (Paratransit is recognized as special transportation services for people with disabilities, often provided as a supplement to fixed-route bus and rail systems by public transit agencies.) Bus: Yes No Paratransit: Yes No If "No" to either, explain Medical Reason: __________ __________________________

3: Patient can only be transported by stretcher. Will patient need medical attention during transportation (form is only valid for three (3) months) Yes No If "Yes", please explain: ____

4: Does patient have a wheelchair? Yes No Type: Manual Electric Scooter
Is patient able to transfer out of their wheelchair WITHOUT assistance? Yes No (LogistiCare does not provide wheelchairs).

5: For safety reasons, please circle the most appropriate weight range of the patient with their wheelchair/EWC/scooter:
Up to 200 lbs. 201 – 350 lbs. 351 – 500 lbs. 501 – 600 lbs. 601 - 800 lbs. Over 800 lbs.

6: How far can the patient travel unaided?
Walking: __________less than 100 Yards ______100 to 300 Yards ________300 to 600 yards ________more than 600 yards
In wheelchair: ________less than 100 Yards ______100 to 300 Yards ________300 to 600 yards ________more than 600 yards

7: Patient uses a cane/walker. Yes No How many yards can the patient walk independently using this equipment?__________________

8: Does the patient have any serious psychological, social or mental dysfunctional impairments that could affect their transportation services? Yes No If "Yes", please briefly explain? ____
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9: Is period of incapacity permanent? Yes No If No, expected expiration date of restrictions:_________________________________

10: Please list any other factors that LogistiCare Solutions should take into consideration when providing transportation for this patient:
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I certify that the information contained herein is true and accurate to the best of my medical judgment and knowledge. ____________________
Physician/Provider Signature

Please return this information as soon as possible to:

LogistiCare Solutions Attn: Utilization Review **Address:** 2995 Ryan Drive SE Ste. 200 Salem, OR 97301 **or FAX:** (855) 848-8637
Phone: 1-844-287-6698