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UT DHHS MCD EXCESSIVE MILEAGE
PROVIDER CERTIFICATION OF MEDICAL NECESSITY FORM
FOR TRANSPORTATION OVER 75 MILES

FAX to Modivcare: (877) 637-9079
PHONE: (855) 563-4405
TTY: (866) 288-3133

<table>
<tr><th colspan="3">MEMBER INFORMATION</th><th colspan="2">MEDICAL PROVIDER INFORMATION</th></tr>
<tr><td>Date of Birth:
_____/_____/_____</td><td>Sex:
☐ M ☐ F</td><td>Age:</td><td>Member ID#:</td><td>Phone #:</td></tr>
<tr><td colspan="3">Patient/Member Name (Last, First, MI):</td><td colspan="2">Referring Medical Provider Name and Address:</td></tr>
<tr><td colspan="3">Medical Provider Name and Address:</td><td colspan="2" rowspan="2">If transportation is NOT medically necessary, please fill out this box and return the form by fax to (877) 637-9079.

☐ Transportation is not medically necessary.*

Date: _____

Signature: _____

* Pursuant to Utah Medicaid Provider Manual Medicaid Transportation Services 2024 Section 2 (1-4), all NEMT must be to the nearest appropriate Medicaid provider or facility that can provide the service.</td></tr>
<tr><td colspan="3">If transportation is medically necessary, please continue filling out this form below.</td></tr>
<tr><th colspan="5">REQUIRED BY MEMBER AND APPROVED BY MEDICAL PROVIDER</th></tr>
<tr><td colspan="5"><u>Medically Necessary</u>

☐ 75 Miles</td></tr>
<tr><td colspan="5">Please provide justification of medical necessity for transportation for over 75 miles outside of the home community. (Additional documentation may be attached if necessary.)

_____

_____

_____

_____

Estimated duration of level of service (check one): ☐ 6 Months ☐ Other:</td></tr>
</table>

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This certification may be completed and signed only by the member's attending physician, physician assistant, or certified nurse practitioner to confirm a medically necessary level of service.

Knowingly providing false information on this certification may constitute fraud and may prevent the patient/member from receiving further transportation services. If you have any questions, please contact Modivcare's Facility Assistance Department at (855) 563-4405.

I certify that to the best of my knowledge, the above information is true, accurate, and complete and the level of service required for the patient's/member's transport is medically necessary for the patient's/member's health.

NAME:_____ SIGNATURE:_____ DATE: _____

Fax completed form to:	**(877) 637-9079**
Mail completed form to: **(If mailing, please allow 7-10 days for processing.)**	**Modivcare Facility Department** **4615 E. Elwood Street, Suite 300** **Phoenix, AZ 85040**