



UTAH PHYSICIAN'S CERTIFICATE

This is a REQUIRED form that only Doctors, Nurse Practitioners, Physician Assistants, Doctors of Physical Therapy, or Registered Nurses must fill out to assist ModivCare to determine any specific transportation restrictions for patients due to medical conditions. **These statements will be reported to State DHHS Medicaid who requires that this form be 100% completed to be valid.** The patient will be offered ONLY four consecutive weeks of trips if this form is not completed or returned.

Today's Date: _____ Patient's Name: _____

Medicaid ID Number: _____ DOB: _____ Phone #: _____

Patient's Address: _____

- 1: You are the Medical Provider who is aware of the above patient's mobility capabilities.
 Yes No **If "No", please STOP and return form.**
- 2: Is the member able to use an available vehicle or can the member be transported via a family member or friend?
 Yes No
- 3: Does the patient have the physical ability to safely get to, wait for and ride a bus or Para Transit even during the pandemic and extreme weather conditions (Snow, Heat) Yes: Distance able to walk _____ No
- 4: Does the patient require a companion (17 years or older) for medical assistance like (i.e. blind, minor, disability, mentally handicapped, non-verbal, etc.). Yes No **If "Yes", please explain:** _____

NOTE: If "Yes", all trips will require an escort until informed in writing by a physician that an escort is no longer needed.

- 5: Is the patient able to safely ambulate/transfer to the vehicle? Yes No
If **Yes:** Does the patient need/require any mobility device? Cane Walker Leg Scooter
 Manual Wheelchair (W/C) Electric W/C Make/Model _____
If **NO:** Does the member require a mobility/WC vehicle? Yes No
If **YES:** Manual W/C Electric W/C? Weight of the patient w/o the W/C _____
- 6: Does the patient have any serious psychological, social or mental dysfunctional impairment that could affect their transportation services or require a travel companion? Yes No **If "Yes", please explain:** _____

- 7: Is period of incapacity permanent? Yes No **If "No", expected expiration date of restrictions:** _____
- 8: Does the patient require stretcher transport? (Valid for only three (3) months) Yes No
If "Yes", please explain: _____
(Modivcare does not provide any kind of medical aid, support or equipment)

I certify that the information contained herein is true and accurate to the best of my medical judgment and knowledge.

Medical Professional's Name (Printed): _____

Title: MD/DO/DPT PA NP/RN Signature _____

Office Phone: _____ Office FAX: _____

Please return this information as soon as possible to:

ModivCare: Attn: Exceptions Dept Phone: 855-563-4405 FAX: 877-637-9079

Non-Emergency Medical Transportation for the Utah DHHS Medicaid Program