Physician Certification Form – Request for Non-Emergency Medical Transportation (NEMT)

Please complete the Alameda Alliance for Health Physician Certification Form – Request for Non-Emergency Medical Transportation (NEMT) Form to request for NEMT services for Alliance members. NEMT includes transportation by ambulance, wheelchair, and gurney vans for medically necessary covered services, specifically when the patient is non-ambulatory. All NEMT trips include door-to-door service.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Please complete the form and fax or send a secure email* to:
   Alameda Alliance for Health
   ATTN: Case and Disease Management Department – Request for Transportation
   Fax Number: **1.510.747.4130**
   Secure Email*: **DeptCMDM@AlamedaAlliance.org**
   If you have questions about how to send a secure email, please visit **www.alamedaalliance.org.*

Questions? Please call the Alliance Case Management Department at **1.510.747.4512**.

Please Note: A PCS form is only required for NEMT. A PCS form is not required for non-medical transportation (NMT) level of service such as taxi or car. To request and schedule NMT services, Alliance members can call Alliance Transportation Services toll-free at **1.866.791.4158.**

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Phone Number: _____ ☐ Home ☐ Cell

SECTION 2: TRANSPORTATION NEEDS

Non-emergency medical transportation (NEMT) request *(please select only one (1) level of service):*

- ☐ Air transport (additional verification information needed for approval)
- ☐ Ambulance (including BLS, ALS, CCT, SCT, bariatric patients, LS, and patients requiring oxygen not self-administered or regulated)
- ☐ Litter van/gurney van (for bedbound patients, including bariatric patients)
- ☐ Wheelchair van (including bariatric patients)

SECTION 2: TRANSPORTATION NEEDS (cont.)

Start Date: _____

Duration:

- ☐ 3 months
- ☐ 6 months
- ☐ 9 months
- ☐ **12 months (max duration)**
- ☐ Other: _____

SECTION 3: FUNCTION LIMITATIONS JUSTIFICATION

Please describe the member's specific physical and medical limitations that prevent the member's ability to reasonably ambulate without assistance or be transported by public or private vehicles *(please select only one (1)*:

- ☐ Member is a dialysis recipient
- ☐ Member has leg weakness, mobility limitations, or fall risk
- ☐ Member has severe mental confusion
- ☐ Other:

SECTION 4: CERTIFICATION FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The provider who is responsible for providing care for the member is responsible for determining the medical necessity for transportation. This certificate can be completed and signed by an MD, DO, PA, NP, CNM, physical therapist, speech therapist, occupational therapist, or mental health or substance use disorder provider who is employed or supervised by a hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate, except for requests relating to hospice or home health services, which must be signed by an MD or DO.

Provider Last Name: _____ Provider First Name: _____

Provider Credential: _____ Phone Number: _____

Signature: _____ Date: _____