



modivcare

Attn: Facilities Department
Fax: 877-457-3316 Phone: 866-527-9945

Closest Provider Certification

PLEASE PRINT OR TYPE ALL INFORMATION BELOW.

**Date:*

Please fill out the following questions in order for us to authorize transportation services.

- 1) *Patient's Name: *Phone #:
- 2) *Patient's State Medicaid ID#: *DOB:
- 3) Patient's Pick up Address: *County:
- 4) Physician's Name: *Phone #
- 5) *Physician's Address: *County:
- 6) *Name of HMO / DUAL: Caseworker: _____
- 7) *Total one way mileage for trip *Treatment (if specialist what type):
- 8) Is this the closest available provider for this treatment type ? ____ Yes ____ NO

If Other Must Explain:

Authorized Signature (HMO or MACC Personnel)

Please Print Name and Title / Today's Date

***** *(Signature must be in blue ink; stamped signatures will not be accepted)* *****

Falsifying information on this document may be construed as fraud and may prevent the client from receiving further transportation services through our office. If you have any questions please contact above fax or phone number. All forms must be returned within 10 business days.

PRIVACY NOTICE This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed. It may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination or copying of this message or any attachment is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return e-mail and delete this message, along with any attachments, from your computer.

Modivcare Employee (Print full name).

Site:

Denied Trip Date of service

Denied Trip Number