SafeRide Health

Health Care Provider Statement of Medical Need

HEALTHCARE PROVIDER: Please check the appropriate Section(s) that applies to your clients' needs to ensure that SafeRide Health provides Non-Emergency Medical Transportation (NEMT) that is appropriate for your patient's medical condition and/or is medically necessary.

Client Information:		
Client Name:	Date of Birth:	Medicaid ID:
Medicaid Service Diagnosis Code:		
☐ **Section A. Attendant Services:**		
☐ Adult client requires an attendant during transport		
☐ Child younger than 14 years of age requires **both** parents during out-patient visits or in-patient stay		
Justification:		
☐ **Section B. Transportation Mode:** [*Indicate whether the client's medical condition prohibits use of*]:		
☐ Mass Transit ☐ Shared Ride (more than one passenger in the vehicle during transport) ☐ Other – Please Specify: _____	☐ Paratransit ☐ Commercial Air	
Section C. Inpatient Services:		
Facility Name:		
Address:		
Admission Date:	Projected Discharge Date:	
Section D. Out-of-State/Long Distance Travel: [*Supporting documentation may be required*]		
☐ Required services are not available within the State of Texas ☐ Required services are not available in the county or adjacent county of residence		
Facility Information:		
Name:	Phone: ( )	
Address:		
Receiving Physician:	NPI:	
Name:	Phone: ( )	
Address:		

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Referring Physician or Physician Completing Form:	
Printed Name:	NPI:
Address:	
Phone Number: ( )	Fax Number: ( )
Signature:	Date:

Please Fax Completed Form to:

SafeRide Health

Attention: Verification Dept.
Fax Number: 888-534-9598
Phone Number: 888-932-2331

SafeRide Health Use Only:	
☐ Approved ☐ Not Approved	
Reviewer:	Date:
Notes:	