**Healthcare Provider Statement of Medical Need**

Healthcare Provider: Please check the appropriate section(s) that apply to your Clients’ needs to ensure that the Managed Transportation Organization (MTO) 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/Legal Guardian 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  Para-transit  Shared Ride (more than one passenger in the vehicle during transport)  Commercial Air  Other – Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **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  Justification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Facility Information: | | | |
| Name: | | Phone: | |
| Address: | | | |
| Receiving Physician: | | NPI: | |
| Name: | | Phone: | |
| Address: | | | |

|  |  |
| --- | --- |
| Referring Physician or Physician Completing Form: | |
| Printed Name: | NPI: |
| Address: | |
| Phone Number: | Fax Number: |
| Signature: | Date: |

**Please fax completed form to MTM, Inc.**

**Attention: Texas Care Management**

**Fax Number: (877)-406-0658**

|  |  |
| --- | --- |
| (MTM, Inc.) Use only | |
| Approved | Not Approved |
| Reviewer: | Date: |
| Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |