**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.

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| **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 stayJustification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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 residenceJustification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 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 MTM, Inc.**

**Attention: Texas Care Management**

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

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