Long Distance Justification Form

Member's referring or rendering healthcare provider must complete this form

Member's Name: ____ D.O.B.:_____

Member's Medicaid #: _____ Appt. Date: _____

You have referred and/or will be treating the above named Member at _____(name of healthcare provider or name of facility).

The Member named above is requesting transportation to a healthcare provider located outside of their covered service area. Members must use the nearest appropriate provider that can accommodate their medical needs.

Please list reason why this Member cannot be treated by a healthcare provider closer to their home:

_____

_____

_____

Type of Specialist this Member was referred to see:

_____

_____

Is this a one time authorization? _____ Ongoing treatment? _____

If ongoing treatment, please specify end date of approval _____

_____ _____

Referring/Rendering Healthcare Provider's Signature

Date

_____

Referring/Rendering Healthcare Provider's Address

Please complete and return this Distance Verification Form at least 5 business days prior to appointment.

Fax: 877-406-0658 Attn: MTM Care Management
750 E Pilot Road Suites G&H
Las Vegas, NV 89119

MTM cannot arrange transportation to the requested location until we review and process this document.