blue california
Promise Health Plan

Request for Non-Emergency Medical Transportation (NEMT) Physician's Certification Statement

Fax: **(323) 889-6506** Urgent Fax*: **(323) 889-5403** Phone: **(800) 468-9935** Monday – Friday, 8 a.m. to 5 p.m.

This form authorizes the provider of transportation to provide Non-Emergency Medical Transportation (NEMT) needed by a Blue Shield of California Promise Health Plan Medi-Cal member. NEMT includes ambulance, litter vans, gurney vans, wheelchair vans, and air transport, and is provided when it is medically necessary, and the patient is not ambulatory. NEMT under Medi-Cal is covered only when the patient's medical and/or physical condition does not allow them to travel by bus, passenger car, taxicab, or other form of public or private conveyance.

This form is not required for:
- Non-Medical Transportation (NMT)
- NEMT when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility.

Member

First name:	Last name:
ID number:	Date of birth:
Diagnosis:	
Address:	ZIP:
City:	State:

Transportation (select multiple types if needs are expected to change in the future)

☐ **Ambulance** Basic Life Support (BLS) ☐ **Ambulance** Advanced Life Support (ALS) ☐ **Ambulance** Specialty Care Transport (SCT)	☐ **Litter/Gurney** ☐ **Wheelchair van** ☐ **Air**	**Effective date**** **End date**** (maximum 12 months)

Justification (required): Provide specific physical and medical limitations that preclude the member's ability to be reasonably ambulatory without assistance or to be transported by public or private vehicles.

Requestor (MD, DO, DMD, DDS, DPM, PA, NP, mental health provider, substance use disorder provider, or certified midwife)

Full name (print):	Title:
Address:	ZIP:
City:	State:
Phone:	Fax:
Provider NPI:	

Certification: This certificate must be signed by a physician, dentist, podiatrist, mental health provider, substance use disorder provider, or physician extender (physician assistant, nurse practitioner, or certified midwife) who is employed or supervised by the hospital, facility, or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this certificate. The signatory must be the provider responsible for providing care to the member and responsible for determining medical necessity of transportation consistent with the scope of their practice. By my signature, I certify that medical necessity was used to determine the type of transport being requested.

Signature:	**Date:**

*To qualify as urgent, the request must meet California Health and Safety Code section 1367.01(h)(2).
**If blank, effective date will be date of signature, and end date will be 12 months after effective date.