MASSHEALTH MEDICAL NECESSITY FORM FOR NONEMERGENCY AMBULANCE/WHEELCHAIR VAN TRANSPORTATION

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

MassHealth pays only for medically necessary nonemergency ambulance and wheelchair van transportation. The transportation provider is responsible for the completeness of this form and must retain the form for six years from the date of service. Pursuant to 130 CMR 450.205, the transportation provider must provide completed forms if the MassHealth agency requests them. The MassHealth agency will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. Please complete each section and field relevant to the service being provided. Fields that are not applicable to the service provided may be left blank.

1. Trip Information

Number of trips requested | Transportation requested ☐ Wheelchair Van ☐ Nonemergency Ambulance

Date(s) of service (recurring transportation can only be authorized for up to a 30-day period, beginning with the date of the first trip):

Medical service provided to member at destination

2. MassHealth Member Information

Name

MassHealth ID Number | Date of Birth / / | Gender ☐ M ☐ F

3. Pick-up Location

Is pick-up location member's residence? ☐ Yes ☐ No | Is pick-up location a health care facility? ☐ Yes ☐ No

Facility Name (if pick-up location is a health care facility, including a facility at which member resides)

Street Address

City | State | Zip

4. Destination Information

Is destination member's residence? ☐ Yes ☐ No | Is destination a health care facility? ☐ Yes ☐ No

Facility Name (if destination is a health care facility, including a facility at which member resides)

Street Address

City | State | Zip

5. Transportation Provider Information

Name EasCare Ambulance Service

NPI or PIDSL 1316942162 | Tel.# 617-740-9200 | Fax # 617-740-9292

continued on back →

6a. Medical Necessity Information—Wheelchair Van Requests Only

- ☐ Member resides in an institutionalized setting and uses a wheelchair
- ☐ Member resides in an institutionalized setting and has a severe mobility impairment preventing member from using other transportation
- ☐ Member resides in an institutionalized setting and needs to be carried up or down stairs (because member is unable to walk up or down stairs or cannot walk without the assistance of two persons)
- ☐ Member resides in the community and needs mobility assistance from transportation provider personnel to exit his or her residence or to move from his or her residence to the vehicle

6b. Medical Necessity Information—Ambulance Requests Only

- ☐ Member is continuously dependent on oxygen.
- ☐ Member is continuously confined to bed.
- ☐ Member is classified as an American Heart Association Class IV patient with a disease of the heart.
- ☐ Member is receiving intravenous treatment.
- ☐ Member requires transportation after cardiac catheterization.
- ☐ Member has uncontrolled seizure disorders.
- ☐ Member has a total body cast.
- ☐ Member has hip spicas or other casts that prevent flexion at the hip.
- ☐ Member is in an isolette (incubator).
- ☐ Member is in need of restraints because the member is possibly harmful to himself or herself or others. (This includes persons transported under M.G.L. c. 123, § 12 for temporary hospitalization by reason of mental illness.)
- ☐ Member is heavily sedated.
- ☐ Member is comatose.
- ☐ Member has the following medical condition making ambulance transportation necessary.

_____

_____

_____

7. Requesting Provider Attestation

NOTE: The requesting provider must 1) have adequate knowledge of the member's condition to attest to the information contained in the form; 2) be one of the provider types identified below; and 3) be enrolled in MassHealth (or, in the case of a physician designee, be a registered nurse supervised by a physician who is enrolled in MassHealth).

ATTESTATION: I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider identified below. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature	Date	Print name
NPI (if applicable)	Tel. #	Fax #

Provider Type: ☐ Dentist ☐ Managed care representative ☐ Nurse midwife ☐ Nurse practitioner ☐ Physician
☐ Physician assistant ☐ Physician designee (Registered Nurse) ☐ Psychologist

Physician designees only: Provide the following information for supervising physician.

Name

NPI	Tel. #	Fax #