MEDICA®

SPECIAL TRANSPORTATION:
CERTIFICATION OF NEED

State law prohibits reimbursement of special transportation for Minnesota Health Care Program recipients without a current and approved Certification of Need form signed by the attending physician, nurse practitioner, clinical nurse specialist, or physician assistant working under the delegation of the attending physician.

(*Please print*) **Today's Date**: _____/_____/_____

Medica Member ID Number: ____

Medica Member's Name: ______________________________ **Date of Birth**: ____________________

☐ **No - the member cannot be safely transported without escort by private auto, taxi or bus. (Approval)**
☐ **Yes - the member can be safely transported without escort by private auto, taxi or bus. (Denial)**
If yes, member may be eligible to receive transportation to covered medical appointments.
To arrange transportation, members should call Medica's "**Provide-A-Ride**" service at: **952-992-2292** or **1-800-601-1805**

Special Transportation Medica Provider ID Number: ____________________________________

Special Transportation Provider Name: ____

Phone Number: __________________________ **Fax Number**: ____________________________

Special Transportation Provider Address: (If no Medica Provider Number is available/known)

____

City: **State**: **ZIP**:

Medica Provider ID Number: ____

Medica Provider Name:____
(Attending Medical Physician, Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant)

Diagnosis/ICD-9 Code(s): ____

Please specify member's physical or mental impairment requiring special transportation:
(Physiological disorder, physical condition, or mental disorder that prohibits access to, or safe use of, common carrier transportation)

____

____

Check one:
__Permanent Wheelchair ___Temporary Wheelchair ___Ambulatory ___Ambulatory w/Assistance ___Stretcher
Permanent impairment/disability: ☐ **Yes** ☐ **No** If no, expected duration of impairment/disability: ______________

***Anticipated First Ride Date**: ________________ **End Date**: ______________ (*Expires 1 year from 1st Ride Date*)

I certify that I have reviewed this member's medical history/condition, and that the member meets Minnesota Statute section 256B.0625, subdivision 17(b) criteria that the member has a physical or mental impairment that would prohibit the recipient from safely accessing and using a bus, taxi or other commercial transportation, or private automobile.

Medica Provider Signature: ______________________________ **Date**: _____/_____/_____
***Note:** Incomplete forms and forms submitted 45 days, or more after the member's first ride date will not be accepted.

Submit the completed form prior to the first ride date to: **Medica Provider Data Department**
Fax Number: **952-992-8090**

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