Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) PRESCRIPTION/ATTESTATION OF MEDICAL NECESSITY

In order to process your request, complete all form fields below including physician signature and date of signature. **If any field is incomplete, request cannot be processed and may result in delay of service.** This form constitutes a prescription and attestation of the medical necessity for transportation services. Ventura Transit Service (VTS) requires at least 48 hours prior notice for all standard requests. Please submit this form in a timely manner to allow for verification of the information provided below

1. Member Name: _____ 2. GCHP ID Number: _____

3. Member's Preferred Contact Number: _____ 4. GCHP Member DOB: _____

5. Servicing Provider/Facility: _____ 6. Language Preference: _____

7. Date of Service (DOS) for Authorization – Not to Exceed One (1) Year and Dependent on Member Eligibility

From: _____ To: _____

8. Days of the week transported to above appointment(s):

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐ Varied

9. Requests Caregiver: ☐ Yes ☐ No Reason: _____

10. Diagnosis: _____

11. Medical purpose/justification for visit(s): _____

12. Patient mobilizes via: ☐ Wheelchair ☐ Walker ☐ Cane ☐ Bed Bound ☐ Other (describe) _____

13. Mode of transportation requested: ☐ Ambulance ☐ Wheelchair Van ☐ Lifter Van ☐ Air ☐ Other (describe) _____

14. Beneficiary functional limitations, (specific physical or mental), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance:

☐ Wheelchair bound and unable to self-transfer
☐ Mental Confusion
☐ Respiratory Disorder
☐ Other (please describe): _____
☐ Hemodialysis
☐ Visual Impairment

15. ☐ Private or public transportation is medically contraindicated.

16. By signing this form, Provider acknowledges that medical necessity was used to determine the type of transportation being requested.

17. Provider Name: _____ 18. Date: _____

19. Provider Signature: _____ 20. License Number: _____

21. Office Contact Name: _____ 22. Phone: _____

23. Provider Specialty: _____ 24. Fax: _____

25. Provider Address (number, street, city, zip code): _____

PROVIDER: Please FAX Completed Form to GCHP at: 1-855-883-1552