949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

# Certification of Medical Necessity of Mode of Transportation

Medicaid-covered services (Fax to: 1-866-790-8808)

**Instructions:** Type or print clearly. All areas of this form must be completed and signed by a medical care provider* to verify the mode of transportation required for the member.

**1. Member Information:**

Name _____ Date of Birth _____

Address _____ Phone _____

**2. Insurance Information:**

'Ohana Plan ID #: _____ Medicaid ID #: _____

PCP Name: _____ Phone: _____ Fax: _____

**3. Certification:**

☐ The member does not have transportation available through self, family, friends, volunteers or others
☐ The member cannot ride public bus transportation

**4. Mode of transportation required for Medically Necessary Medical Appointments – check the most cost effective mode of transportation that member can safely take:**

☐ The member can ride curb to curb Handi-Van service (Handi-Van evaluation and approval required)*

*TheHandi-Van: Member can call 1-808-538-0033 for more information or to schedule an in-person interview.

☐ The member requires curb-to-curb taxi service, provide explanation below:

☐ Medical Issue ☐ Functional Issue ☐ Cognitive Issue ☐ Mobility Issue ☐ Other

Explain: _____

☐ The member requires door-to-door taxi service, provide explanation below:
Medical and/or Functional issue that necessitates door-to-door taxi Service:

☐ Medical Issue ☐ Functional Issue ☐ Cognitive Issue ☐ Mobility Issue ☐ Other

Explain: _____

**5. Special Considerations – Check all that apply**

☐ The member needs one personal assistant/escort throughout duration of transport (all members under age 18 need escort)
☐ The member needs two personal assistants/escorts throughout duration of transport
☐ The member uses a wheelchair for transport when outside a vehicle
☐ The member uses a walker when ambulating
☐ The member must be provided non-emergency stretcher service during transport
☐ The member has an elevator
☐ Additional passengers are problematic, no multi-loading

I, _____ , the medical provider *(*such as: physician, physician assistant, nurse practitioner or service coordinator),* have evaluated this member and certify that he or she is medically/functionally appropriate for the mode of transportation designated in **Section 4 above**.

**Certifying Medical Provider Information:**

Medical Provider Name: (Last, First, Middle) _____ 'Ohana Provider ID#: _____

Phone Number: _____ Fax Number: _____

Contact Person at Office/Phone Number: _____

Medical Provider Signature: _____ Date: _____