



Provider Certification Statement (PCS)

For Non-Emergency Medical Transportation (NEMT)

In order to appropriately evaluate your request, **complete all form fields** below including **provider signature** and **date of signature**. If any field is incomplete, further documentation may be requested. **This form constitutes a prescription.** [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323, PHC Policy M CCP2016, APL 17-010 and the Medi-Cal Provider Manual]

1. Patients Name	2. Medi-Cal I.D. number
3. Dates of Service (DOS) Please complete for the desired date range of NEMT justification. Not to exceed 12 months and dependent on member eligibility.	
From: _____ To: _____	
4. Patient mobilizes via: Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Other (describe): _____	
5. Functional limitations, (specific <i>physical</i> or <i>mental</i>), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: <i>(If patient can utilize taxi, public transport or gas mileage reimbursement please indicate this here.)</i>	
<input type="checkbox"/> Patient is wheelchair bound and unable to self-transfer <input type="checkbox"/> Dialysis <input type="checkbox"/> Other (describe): _____	
6. Based on 4 and 5, above, the required mode of transport is:	
<input type="checkbox"/> Public Transport – Member is capable of utilizing local bus or para-transit system without assistance	
<input type="checkbox"/> Taxi – Member can get from their home to the vehicle and transfer without assistance	
<input type="checkbox"/> Wheelchair Van – Member must be transported by wheelchair because of disabling physical or mental limitation or is unable to self-transfer	
<input type="checkbox"/> Gurney Van – Member must be transported in a prone or supine position because member is incapable of sitting upright	
<input type="checkbox"/> Ambulance – Member's medical condition prevents the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)	
<input type="checkbox"/> Air Ambulance – Member's medical condition prevents the use of ground transport (describe): _____	
7. Provider signature (Acceptable signatures: MD, DO, PA, NP, CNM, Physical, Speech & Occupational Therapists, and Mental Health/Substance use disorder providers. Personal signature only. No proxy. No stamps) <i>I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.</i>	8. Date
	9. Medi-Cal Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Physician Name (print or type)	11. NPI number
12. Provider specialty (print or type)	13. Telephone number (With area code)
14. Provider address (number, street, city, zip code)	15. Fax Number (With area code)