Medical Certificate of Transportation Services (MCTS)

The patient's medical provider completes this form indicating the most medically appropriate mode(s) of transportation the patient is eligible to receive under Non-Emergency Medical Transportation (NEMT). If the form has not been completed or has expired, the medical provider or the medical provider's approved staff must complete this form and submit it to Veyo via fax, email or via online form. For any ambulance mode of transportation, this form must be completed and submitted online at www.medicaidco.com, emailed, faxed, or mailed to Veyo.

This document cannot be completed by a non-emergency transportation provider

Patient Name: _____ Patient Date of Birth: _____ Patient Medicaid Number: _____

Please check all medical conditions below that apply to this patient:

☐ Requires Oxygen that is self-administered
☐ Traveling with ADA service animal
☐ Bariatric patient - Weight _____ Height _____
☐ Pediatric patient

Please check one:

1) Does member have access to a vehicle? □ **Yes** □ **No**
   a) If No, please check the Public Transportation □
   b) If Yes, please check the Mileage Reimbursement □
2) Does member have a medical condition or disability that prevents them from taking public transportation? □ Yes □ No
   a) If Yes, please provide details of condition or disability that prevents them from utilizing public transportation.

Details

☐ **ADA Paratransit**
Is the patient currently registered through the local Access-A-Ride, Greeley Evans Transit, Transfort, or similar ADA Paratransit System?

☐ **Ambulatory**
Is the patient able to get into and out of a regular sedan style vehicle? This includes patients who use a cane, walker, transfer wheelchair but are able to step into a regular car and do not require a lift.

☐ **Wheelchair Van Service**
Is this patient wheelchair bound and has their own wheelchair
Wheel base of the patient's wheelchair? _____
Approximate weight of the wheelchair? _____

☐ **Non-Emergency Ambulance Service**
□ Basic Life Support (BLS)
□ Advanced Lift Support (ALS)

Please explain medical condition requiring BLS/ALS transport.

I affirm that the above statements are true and accurate to the best of my knowledge and federal funds will be used for the service I am requesting on behalf of my patient and the most medically appropriate service is being requested.

Name of Licensed medical provider: _____ Title: _____
Signature of medical facility staff: _____ Date: _____
Phone number of medical provider: _____ Expiry Date: _____
Or Expiry Date Indefinite □

This form has changed and is no longer required to expire after 6 months.