INCOMPLETE FORMS WILL NOT BE PROCESSED

PHILADELPHIA MATP

PHYSICIAN'S TRANSPORTATION RESTRICTION FORM

The purpose of this form is for physicians to communicate to LogistiCare specific transportation restrictions of patients due to a medical condition. The restrictions and requirements declared by physicians using this form will be used by LogistiCare to determine the best means of transportation for the patient. LogistiCare will verify the information provided on this form and report discrepancies to the Department of Human Services.

THIS FORM MUST BE COMPLETED IN FULL OR IT WILL NOT BE PROCESSED RESULTING IN A DELAY IN TRANSPORTATION SERVICES.

Today's date: ______________________ Patient's Name: ____

Patient's Medicaid ID Number: ______________________________________ Patient's DOB.:_____/_____/_____

To be completed by the treating Physician (**Please Print**):

Transportation Needs: (Please answer all)

1. Patient is medically unable to use public transportation. ☐ Yes ☐ No
2. Patient is medically unable to walk 1/4 mile. ☐ Yes ☐ No
3. Patient is medically able to use public transportation ONLY if accompanied by a companion. (In such case LogistiCare will pay for companion fare.) ☐ Yes ☐ No
4. Patient requires an escort. ☐ Yes ☐ No
   Please indicate Medical Reason for escort (required) ____
   ____
5. Patient requires low riding vehicle. ☐ Yes ☐ No
   Please indicate Medical Reason for low riding vehicle (required) ______________________________________
   ____
6. Patient needs wheelchair vehicle. ☐ Yes ☐ No
7. Patient requires medical treatment outside of Philadelphia County: ☐ Yes ☐ No
   Please indicate Medical Reason out of county and which county (required) ____________________________
   ____
8. Does this patient travel by public transportation for other purposes such as shopping, etc.? ☐ Yes ☐ No
9. List the medical condition which requires specified transportation needs above (Please Print Clearly):
   ****This form will not be accepted without a medical reason for the need for paratransit services.****
   ____
   ____
   ____
10. **Mode of Transportation required based on the patient's medical necessity** (please check only one):
    ☐ **Mass Transit** ☐ **Paratransit** ☐ **Wheelchair Van** (wheelchair certification form also required)
11. **Period of Incapacity:** **Permanent?** ☐ Yes ☐ No

    If no, expected Expiration date of Restrictions: ____________________

Physician's Name (print): ____

Physician's phone no.: (______) _______-____________________

Physician's Signature: X ____ Date: ______________

I certify that the information provided for this member represents a true evaluation of the member's medical condition. I understand that this form is utilized by LogistiCare to determine the appropriate mode of transportation for the member based on their medical condition. Any discrepancies reported in the information provided can be misrepresentation of MATP fund which constitutes Medicaid fraud.

Please return this form via fax to LogistiCare, Philadelphia:
Attn: Facilities Department
Phone: 1-877-835-7426
Fax: 1-877-835-7432

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