Attn: Facilities Department
Fax: 877-457-3316 Phone: 866-527-9945

Closest Provider Certification

PLEASE PRINT OR TYPE ALL INFORMATION BELOW. **Date:* _____

Please fill out the following questions in order for us to authorize transportation services.

1) *Patient's Name:_____ *Phone #: _____

2) *Patient's State Medicaid ID#: _____ *DOB: ____/____/_____

3) Patient's Pick up Addres _____ *County_____
Street City Zip Code

4) Physician's Name: _____ *Phone #_____

5) *Physician's Address: _____ *County_____
Street City Zip Code

6) *Name of HMO / DUAL _____Caseworker: _____

7) *Total one way mileage for trip: ____ *Treatment (if specialist what type): _____

8) **(This question should be filled out by HMO or MACC personnel only)**
Is this the closest available provider for this treatment type? _____Yes _____No

If Other Must Explain:

_____

_____

_____ _____
Authorized Signature (HMO or MACC Personnel) Please Print Name and Title

********* ***(Signature must be in blue ink; stamped signatures will not be accepted)*** *********

Falsifying information on this document may be construed as fraud and may prevent the client from receiving further transportation services through our office. If you have any questions please contact above fax or phone number. All forms must be returned within 10 business days.

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Logisticare Employee(Print full name)_____ Site _____NJ/NV

Denied Trip Date of service _____ Denied Trip Number _____