NJ Operations
P.O Box 11647
New Brunswick, NJ 08906

MEDICAL PROVIDER LEVEL OF SERVICE CERTIFICATION

Required for All Patients / Members Using Wheelchair or Stretcher Transport

FAX # 877-457-3316

PHONE # 866-527-9945

This form is only for those patients / Members who do not require advanced medical monitoring. Please contact Facility Assist to obtain the correct form for any patient who is ambulatory or requires advanced medical monitoring

Patient / Member Information:			Medical Provider Information:	
DOB: ____/___/___	Sex: M F	Age:	Fax #: ( )	Phone #: ( )
Medicaid ID #:			Medical Provider Name & Address:	
Patient / Member Name (Last, First, MI):				
Preferred Transportation Provider:				
Weight _____ Height _____ # of Steps _____				

LEVEL OF SERVICE REQUIRED BY PATIENT / MEMBER & PRESCRIBED BY MEDICAL PROVIDER (Choose only one)

☐ **Stretcher Transport**	☐ **Wheelchair Transport**
BLS ☐ Bariatric ☐ Oxygen ☐ L/M_____	Wide/Bariatric Chair ☐ Oxygen ☐ L/M _____

(Please document all conditions that apply)	Medical Necessity Criteria for Stretcher	(Please document all conditions that apply)
___ Patient is unresponsive ___ Pulse Oximetry Monitoring ___ BMI >80 ___ Unrepaired or recent fracture/Joint replacement	**Bed Confined: (must meet all 3 criteria)** ___ Unable to stand or pivot ___ Unable to walk ___ Unable to sit in a chair or wheelchair	___ Sacral wounds, specify stage and location below. ___Safety or other issues, specify: _____

Summary of patient's / Member's medical history, including physical exams, laboratory results, and prescriptions, establishing the medical necessity for the prescribed level of service: (Additional documentation may be attached when necessary.)

Estimated duration of Level of Service. Check One 60 Days ☐ 90 Days ☐ 365 Days ☐

Knowingly providing false information on this Certification may constitute fraud and may prevent the patient / Member from receiving further transportation services. If you have any questions please contact LogistiCare's Facility Assistance Department at **866-527-9945.**

I certify that to the best of my knowledge, the above information is true, accurate and complete and the level of service required for the patient's / Member's transport is medically necessary for the patient's / Member's health.

PRINTED TITLE: _____ **PRINTED NAME:** _____

SIGNATURE: _____ **DATE:** _____

This Certification may be completed and signed only by the patient's / Member's medical provider to confirm a medically necessary level of service. The medical provider must be one of the following: attending physician, physician's assistant, Registered Nurse, or Nurse Practitioner.