

I SERVICES

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NJ Operations

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NEW JERSEY NON-EMERGENCY TRANSPORTATION SERVICES MEDICAL PROVIDER CERTIFICATION FORM FOR SPECIALTY CARE TRANSPORTS (SCTU) ONLY

PLEASE FAX COMPLETED FORM TO: 877-457-3316

The purpose of this form is to identify if the patient meets the following criteria to make them eligible for the SCTU transportation services as defined by the OEMS Regulations (Section 8:41-10.2)

- Does the patient have a life-threatening illness or injury?
- Does the patient s condition require constant attendance and management of medically necessary supplies and services by a critical care nurse?

Note: Statements made by medical providers regarding patient transportation restrictions are subject to review by the New Jersey Medicaid Fraud Division of the Office of State Comptroller.

TO BE COMPLETED BY ME	DICAL PROVIDER (PHYSICIAN, RN, PA, NP): PLEASE PRINT
Today's Date	Patient's Name
Medicaid ID Number	Patient's Date of Birth
CARE REQUIRED DURING	FRANSPORT (please check all that apply):
☐ The patient requires continue	ous cardiac monitoring. (Not pulse ox)
☐ The patient requires continue	ous monitoring of an IV drip.
☐ The patient's condition requires services by a critical care not	res constant attendance and management of medically necessary supplies and irse.
☐ The patient requires deep tra	cheal suctioning.
☐ Requires transportation in a	supine or prone position.
☐ The patient requires an autor	matic ventilator or ventilator assisted mode.
•	ne health provider be travelling with the patient? (If yes, they will be responsible for the patient's equipment, i.e. ventilator, adjusting oxygen.)
☐ Other	
CORRECT LEVEL OF SERV ☐ Wheelchair/MAV – (door thro	MEET ONE OR MORE OF THE ABOVE CRITERIA, PLEASE INDICATE THE ICE BELOW: bugh door assistance and travels via manual or power wheelchair) bed bound, and does not require advanced medical monitoring)
Does the patient r	equire oxygen provided by the transportation provider? YES NO
Medical Provider (MD, RN, PA,	NP) Name (please print):
Medical Provider (MD, RN, PA,	NP) phone number:
Medical Provider (MD, RN, PA,	NP) fax number:
Date: Medical Pr	ovider (MD, RN, PA, NP) Signature:
Physician/RN/ PA/ NP Commer	nts:

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