FORMS

This appendix includes information about how to access the forms that are referenced in the Medical Transportaion manual chapter and where they can be obtained.

The following forms can be found in this appendix:

- **Certification of Ambulance Transportation** – Molina 105 Attachment
- **Certificationof Ambulance Transportation** – Molina 105 Attachment Instructions
- **Verification of Medical Transportation** – Form MT-3
- **Instructions for Completion of Form MT**-3

The following NEMT forms are available at http://new.dhh.louisiana.gov/index.cfm/page/1544:

- **NEMT Program Driver Information Form** – MT-8
- **Transportation Vehicle Inspection Form** – MT-9 a
- **NEMT Request for Inspection (Fleet Addition)** – MT-15
- **Instructions for Completing NEMT Request for Inspection (Fleet Addition) – MT-15**

The following NEMT form is available at http://new.dhh.louisiana.gov/index.cfm/page/1543:

- **NEMT Program Driver's Change Form** – MT-8-C

The following EMS forms are available at http://new.dhh.louisiana.gov/index.cfm/page/1539:

- **Request for Inspection – (Ambulance – Sprint – Air Ambulance)** – ET-05
- **Instructions for Completing EMS Request for Inspection (Fleet Addition) Form ET-05**
- **Medical Response Emergency Vehicle Survey – Ambulances – Minimum Equipment & Supply Needs**
- **Medical Response Emergency Vehicle Survey – Sprint Report – Minimum Equipment & Supply Needs**

Molina 105 Attachment
Revised September, 2003

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name	Origin of Services
ID # of Recipient	Destination
Date of transport	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:
Check One

	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: The patient is bed-confined, i.e. unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable and is not likely to require the attendance of an EMT. ***Describe the medical condition of the patient which requires this type of transport:***
	Non-Emergency Ambulance: Patient will require transportation ____ (number) times a week during the month's ____, ____ (month(s). (year)) to receive (dialysis, radiology, physical therapy). (Dialysis can be authorized for 2 consecutive months).
	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en Route, is ambulatory or wheel chair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reason:
Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there.
	Other *(describe):*

SECTION II (To Be Completed by Treating MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above. Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

I have read the above certification and I have read and understand the instructions on the reverse side of this form.	
	I agree with the determination.
	I disagree with the determination, for the following reasons:

X **Signature of MD/PA/NP/CNS/RN/DON** _____ **Printed Name** _____ **Date**

SECTION III To Be Completed by Ambulance Driver(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date
Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form. Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Molina Form 105. Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services. If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate.

Molina 105 ATTACHMENT-INSTRUCTIONS

CERTIFICATION OF AMBULANCE TRANSPORTATION

Purpose
Molina 105 Attachment is initiated to support medical necessity for ambulance transportation for those recipients residing in nursing facilities or those recipients receiving dialysis, radiology and physical therapy services. Facility reviewers will review this form to determine whether the facility is properly requesting ambulance transportation services. Ambulance transportation reviewers will review this information to determine the patient's condition meets the need for ambulance transportation.

Preparation
Identifying Information: Recipient name, Medicaid ID number, date of transport, origin of service, destination, and destination address shall be completed by either the ambulance transportation provider or the facility. Every item is to be completed.

Certification of Ambulance Transportation Necessity (Section I): Effective with date of service July 1, 2003, the Department of Health and Hospitals has revised the certification form (Form 105 Attachment). The new form shall replace the Form 105 Attachment 1 currently in use by the ambulance industry. Also, the certification shall require the attending physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse (all applicable sate licensure or certification requirement must be met) or nursing facility director of nursing for LTC residents to certify that the patient's condition meets the need for ambulance transportation services. Ambulance transportation was necessary because other means of transportation would endanger the life or health of the patient. In addition, signed certification statements from physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), registered nurses (RN), or nursing facility director of nursing for LTC residents are also acceptable when professional services are furnished by the same.

Type of Ambulance Transportation Necessary:
There are three types of medical transport available:

1. Emergency ambulance transport is appropriate in case of accidents or sudden medical emergency.
2. Non-emergency ambulance transport is to be utilized when the condition of the patient requires or may require medical care en route. Examples of conditions which could reasonably be expected to require non-emergency ambulance transport are: (1) unstable diabetes; (2) chronic pulmonary diseases requiring use of oxygen during transport; (3) unstable ventilator assistance; (4) IV therapy. Prior scheduling is to be utilized.
3. Non-emergency, non-ambulance transport is appropriate for routine non-emergency transport of wheelchair or ambulatory patients. Prior scheduling is to be utilized.

Medical Professional Statement (To Be Completed by MD/PA/NP/CNS/RN/DON)-(Section II): The Medical Professional Statement section is to be completed only if the recipient's physician has not issued written orders requiring ambulance transportation. Such written orders, if used in lieu of the Medical Professional Statement on this form, must specify the medical condition which requires travel by ambulance, the length of time for which ambulance transport will be necessary, and must be signed and dated by the physician. A copy of the written orders, if pertinent, must be attached to the form.

If no written orders have been issued, the Medical Professional Statement shall be completed by the treating medical doctor, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or the nursing facility director of nursing. (The physician may be the physician treating the patient, the physician who instructed the patient to travel to the medical facility, or the medical director of the facility which received the patient.) The medical professional shall check the appropriate block indicating agreement with the facility statements or indicating disagreement and the reason for disagreement.

Ambulance Driver and Attendant Designation and Signature: The names of the ambulance driver and attendant and their national EMT numbers shall be printed or typed legibly by the transportation provider. The form MUST be signed and dated by the driver and the attendant.

Disposition
The facility may file a copy of the form in the patient's record when transport is provided. In cases involving nursing facilities, this copy shall be completed, signed, and dated by the nursing facility Director of Nursing, the ambulance driver, and the ambulance attendant. The Medical Professional Statement shall also be completed unless the medical professional at the medical destination is to complete this section.

Ambulance transportation providers who submit paper claims or bill electronically shall retain the original of the form in the office available for review for a period of five (5) years from the date of service. Every claim shall have either a copy of the physician's written orders attached or the Medical Professional Statement on the form completed, signed, and dated by the appropriate medical professional.

NOTE: When the Medical Professional Statement disagrees with the certification of medical necessity, non-emergency ambulance transport shall be reimbursed at a rate not to exceed the non-emergency, non-ambulance rate.

Form MT-3 (Revised 05/13)

VERIFICATION OF MEDICAL TRANSPORTATION

Date of Appointment: _____/_____/_____ **Time of Appointment:** _____**AM / PM**

I. RECIPIENT VERIFICATION OF MEDICAL TRANSPORTATION

Transportation Provider Name _____

Recipient's Name _____ Medicaid I.D. _____

Recipient's Address _____
Street City State Zip

Appointment Address _____
Street City State Zip

Having no other form of transportation to receive medical treatment under the Medicaid program, I have requested transportation services from the Department of Health and Hospitals. My signature below acknowledges that I am using transportation to keep a medical appointment. I understand that transportation services can only be used to receive medical services. I understand that if I do not sign this request for medical transportation and return it to the transportation provider, the Department of Health and Hospitals or a duly appointed representative may choose to contact me or the medical provider I am being transported to for the verification that I have kept my medical appointment.

_____ _____
Recipient's Signature Date

II. DRIVER VERIFICATION

Check appropriate block(s)

☐ I certify that I was the driver who provided the above named recipient with transportation to the medical facility.

_____ _____
Driver's Signature Date

☐ I certify that I was the driver who provided transportation for the above recipient from the medical facility to the recipient's home.

_____ _____
Driver's Signature Date

III. MEDICAL SERVICE PROVIDER VERIFICATION

This section must be completed by the medical service provider or his/her representative and returned to the transportation provider by the recipient when the recipient is picked up after the medical appointment. Completion of this section by the signature of anyone other than the medical provider or his/her representative who rendered the services is prohibited and may result in prosecution.

☐ I certify that the above named recipient had an appointment on _____/_____/_____ at _____ AM / PM and received medical services.

☐ I certify that the above named recipient was in the office on _____/_____/_____ at _____ AM /PM but did not receive medical services because _____

_____

Office Stamp (Optional) _____ Signature and Title _____ Date

INSTRUCTIONS FOR COMPLETION OF FORM MT-3

The MT-3 provides verification that a medical appointment was kept. It is completed by the driver and signed by the recipient, the driver and the medical provider or representative to confirm that the trip was completed. If the recipient does not or will not sign the MT-3, an explanation must be given in the "remarks" section of the claim form (Form 106). Following are instructions for completion of the Form MT-3.

Top Section of MT-3:

Date of Appointment: complete with the date of the medical appointment that transportation provided.

Time of Appointment: complete with the actual time of the medical appointment. Circle "AM" or "PM" as appropriate.

I. Recipient Verification of Medical Transportation

Transportation Provider Name: complete with provider's name.
Recipient's Name: complete with recipient's name.
Medicaid I.D.: complete with the recipient's 13-digit ID number.
Recipient's Address: complete with the recipient's complete address including Zip Code.
Appointment Address: complete with the complete address of the appointment including Zip Code.
Recipient's Signature and Date: the recipient must sign and date with that day's date. If the recipient signs with a mark, this mark must be witnessed by at least one person who can sign his/her own name.

II. Driver Verification

The driver of the vehicle should check the appropriate box indicating if transportation was provided to the medical facility OR from the medical facility then sign and date the form under the checked box.

III. Medical Service Provider Verification

The medical provider or his/her representative must complete this section.

If the recipient did not receive medical services, an explanation is required.

An office stamp is accepted, but the medical provider or his/her representative must also sign and give his/her title and date.

The MT-3 may not be signed prior to the service being rendered.

The MT-3 should be returned to the transportation provider.