Non-Emergency Medical Transportation (NEMT)
Physician Certification Statement

INSTRUCTIONS

1. IEHP requires the submission of this Physician Certification Statement form, signed by the Member's Primary Care Provider or treating Provider when requesting for Non-Emergent Medical Transportation (NEMT) services. **All fields must be completed**. This certification will **only be valid for twelve (12) months from the Transportation Start Date** and is valid for all NEMT requests during this 12-month period. The Transportation End Date must be 12 months after the Transportation Start Date.
2. Neither IEHP nor the Transportation Broker may modify the PCS form after the Member's PCP or treating Provider has prescribed the form of transportation, unless multiple modes of transportation were selected below, or a new PCS form is received from the Provider.
3. Requests for Non-Medical Transportation (NMT) (e.g., private car or public transportation) do not require the submission of this form. Members requesting NMT services should be directed to contact Call the Car at (855) 673-3195.
4. **Please fax the completed and signed form to IEHP at (909) 912-1049. We strongly encourage submission of this form online through IEHP's secure Provider Portal. For any questions, please call (800) 440-4347 x2 for Transportation Information.**

MEMBER INFORMATION

Member Name			
Member DOB		**Member IEHP ID**	
Transportation Start Date *(Member's Appointment Date Requiring Transportation – e.g., 6/1/23)*		**Transportation End Date** *(12 months from Transportation Start Date – e.g., 6/1/24)*	

Mode of Transportation Needed. ***Please check (✓) all modes that are appropriate for the Member's physical and medical limitation(s).***

☐ Ambulance ☐ Litter van/ Gurney ☐ Wheelchair van ☐ Car/Sedan ☐ Air

Physical and Medical Limitations. ***Please check (✓) all that applies.***

☐ Paraplegic	☐ Hemiplegic
☐ Non-ambulatory	☐ High fall risk due to (please specify) ____________
☐ Poor exercise tolerance	☐ Requires oxygen
☐ Hemodialysis	☐ Requires extensive medical support (e.g., ventilator, IV) ____________
☐ Dementia	☐ Behavioral issues
☐ Blind	☐ Other (please specify)

CERTIFICATION STATEMENT

I certify and attest that I am the treating Provider/Primary Care Provider for the Member and have determined medical necessity for the transportation indicated above.

Physician/Provider Name		**NPI #**	
Physician/Provider Signature		**Date**	

DHCS Approval: 09/13/23