SOUTHEASTRANS

DRIVING THE FUTURE OF TRANSPORTATION MANAGEMENT

Letter of Medical Necessity for Travel Over Allowed Miles

MEMBER and APPOINTMENT INFORMATION

Name: _____ Trip Date/Time: _____

Medicaid/Medicare Number: _____ Date of Birth: _____ Age: _____

Nature of Appointment: _____

Facility Name / Department: _____

Facility Address: _____

Facility Phone Number: _____

Facility Provider ID: _____

Please answer the following in relation to the above appointment:

Is there a closer facility able to meet the needs of the member? _____ YES _____ NO

Have you verified that facility has an appointment scheduled for the member? _____ YES _____ NO

Does the health plan approve this exceptional transport as necessary? _____ YES _____ NO

Please list the name and relationship of anyone who will be required to travel with the member to this appointment: _____

Health Plan Approver Signature: _____

If member's condition is persistent, you may approve for up to 180 days.

Duration of Approval: _____

Health Plan Approver Signature: _____ **Date:** _____

*Southeastrans, Inc. is the Non-Emergency Transportation Broker for the member referenced. The purpose of this form is to gather information to insure that the requested services being provided to the member is within the guidelines established by both Federal and State Medicaid Agencies. STATEMENTS ON THIS DOCUMENT ARE MADE UNDER THE PENALTY OF STATE AND FEDERAL MEDICAID FRAUD GUIDELINES. **Specifically, you should be aware that it is both a state and a federal crime for a medical provider to: make false statements in connection with services paid for through federal health care programs (42 U.S.C & 1320a-7b; O.C.G.A. & 16-8-3)**. Any discrepancies found will be reported to the appropriate State and Federal Medicaid Fraud Control Units.