

Mobility Determination for Non-Emergency Medical Transportation

Universal Form for All Medicaid Plans

The following form is intended to be completed by any health care professional working with the member, including a health plan care manager or nursing facility staff. The form is intended to be valid indefinitely and can be modified at any time by submitting a new form.

Who is the member enrolled with? Check below:

- | | |
|--|--|
| <input type="checkbox"/> AmeriHealth Caritas New Hampshire | <input type="checkbox"/> BMCHP/WellSense |
| <input type="checkbox"/> NH Healthy Families | <input type="checkbox"/> NH Medicaid/Fee-for-Service |

Patient information:

Last name:		First name:	
Date of birth:		NH Medicaid ID#:	
Member phone number:	Height:	Weight:	
Where does the member reside:			

What mode of transportation is required?

- | | |
|---|--|
| <input type="checkbox"/> Car | <input type="checkbox"/> Non-emergency ambulance |
| <input type="checkbox"/> Wheelchair vehicle | <input type="checkbox"/> Stretcher van |
| <input type="checkbox"/> Carry down steps with a stretcher option | |

Level of mobility

- | | |
|---|--|
| <input type="checkbox"/> Patient requires assistance of trained personnel for safety | <input type="checkbox"/> Unable to ambulate |
| <input type="checkbox"/> Bed confined | <input type="checkbox"/> Unable to get up from bed without assistance |
| <input type="checkbox"/> Unable to sit in a chair or wheelchair | <input type="checkbox"/> Environmental factors like heat or cold affect the patient's mobility |
| <input type="checkbox"/> Requires a bariatric wheelchair or stretcher (select from list): | <input type="checkbox"/> Unable to communicate needs |
| <input type="checkbox"/> Wheelchair (16 - 18 inches wide) | <input type="checkbox"/> Unable to remove self from unsafe situation |
| <input type="checkbox"/> Bariatric wheelchair (20 - 30 inches wide) | <input type="checkbox"/> Attendant/Escort |
| <input type="checkbox"/> Stretcher (24 inches wide) | |
| <input type="checkbox"/> Bariatric stretcher (37 inches wide) | |

- | | | |
|----------------------------------|--|-----------------------------------|
| Wheelchair type: | <input type="checkbox"/> Manual | <input type="checkbox"/> Electric |
| Patient self-propels: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient self-transfers: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient travels with oxygen: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient ambulates independently: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wheelchair weight: | <input type="checkbox"/> lbs or <input type="checkbox"/> kgs | |

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Does patient use any of the following assistive devices?		
<input type="checkbox"/> Walker	<input type="checkbox"/> Cane	<input type="checkbox"/> Service animal
<input type="checkbox"/> Crutches	<input type="checkbox"/> Portable oxygen	
Does the patient have any of the following conditions:		
<input type="checkbox"/> Alertness Issues	<input type="checkbox"/> Curb-to-curb – Member does not need assistance getting in/out of the vehicle or getting to/from their appointment.	
<input type="checkbox"/> Memory Issues	<input type="checkbox"/> Door-to-door – Member does need some assistance getting to/from their residence or their appointment.	
<input type="checkbox"/> Confusion	<input type="checkbox"/> Hand-to-hand – Member requires assistance and supervision during the entire trip. Needs to be greeted at their residence and handed off to an assistant at their appointment.	
<input type="checkbox"/> Legally blind		
<input type="checkbox"/> Deaf		
<input type="checkbox"/> Additional accommodation needs:		
Duration of need: <input type="checkbox"/> Permanent* <input type="checkbox"/> Temporary (form should be updated annually)		
*A new form only needs to be submitted if there is a change in condition.		
Health care professional such as RN, MD, care manager, or case manager must complete, sign, and date this form and attest to the accuracy of the information provided.		
Authorized signature:		Date:
Provider (print name):		Title:
Phone number:		NPI#:

Please fax or email this form to your health plan's transportation broker prior to scheduling your ride.

AmeriHealth Caritas New Hampshire	Phone: 1-833-301-2264 Fax: 1-203-375-0511	Nteamleads@ctstransit.com
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MTM Contact Center for NH Healthy Families	Phone: 1-888-597-1192 Fax: 1-877-406-0658 Attention: MTM Contact Center	CM-CenteneNH@mtm-inc.net
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BMCHP/WellSense	Phone: 1-844-909-RIDE (7433) Fax: 1-877-406-0658	CM-WellSenseNH@mtm-inc.net
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NH Department of Health and Human Services (NH DHHS)	Phone: 1-844-259-4780 Fax: 1-203-375-0511	Nteamleads@ctstransit.com
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