Mobility Determination for Non-Emergency Medical Transportation
Universal Form for All Medicaid Plans

Dear Healthcare Professional:
This form should be completed by a healthcare professional who is aware and participating in the care of the member and who can provide information on the appropriate level of transportation that the individual needs.

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?

- ☐ Car
- ☐ Wheelchair Vehicle
- ☐ Non-Emergency Ambulance
- ☐ Stretcher Van

Level of Mobility

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

Wheelchair type:	☐ Manual	☐ Electric
Patient Self-propels:	☐ Yes	☐ No
Patient Self-transfers:	☐ Yes	☐ No
Patient travels with oxygen:	☐ Yes	☐ No
Patient ambulates independently:	☐ Yes	☐ No

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Does patient use any of the following assistive devices?

☐ Walker ☐ Crutches ☐ Cane ☐ Portable Oxygen ☐ Service animal

Does the patient have any of the following conditions:

☐ Alertness Issues ☐ Memory Issues ☐ Confusion ☐ Legally Blind ☐ Deaf

☐ Curb to Curb* ☐ Door to Door* ☐ Hand to Hand* ☐ Additional accommodation needs:

*Curb to Curb: Member does not need assistance getting in/out of the vehicle or getting to/from their appointment.

*Door to Door: Member does need some assistance getting to/from their residence or their appointment.

*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.

Duration of Need: ☐ Permanent* ☐ Temporary (form should be updated annually)

**A new form only needs to be submitted if there is a change in condition.*

Healthcare professional such as RN, MD, Care Manager, 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 of New Hampshire	Phone: 833-301-2264 Fax: 203-375-0516	Provider@ctstransit.com
MTM Contact Center for NH Health Families	Phone: 888-561-8747 Fax: 877-406-0658 ATTENTION: MTM Contact Center	payme@mtm-inc.net
BMCHP/ Well Sense	Phone: 844-909-RIDE Fax: 844-418-0531	GroupHealth_RideRequest@onecallcm.com
NH Department of Health and Human Services (NH DHHS)	Phone: 844-259-4780	GroupHealth_RideRequest@onecallcm.com