Case Name:
Case Number:
Date:
MDHHS Office:
Specialist / ID: /
Phone:
Fax:
Individual ID:

STATE OF MICHIGAN
Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area. MDHHS employees are prohibited by law from providing legal advice.
Si ústed no entiende esto, llame a una oficina de MDHHS en su área. La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب MDHHS الموجود في منطقتك. يحرّم القانون على موظفي MDHHS إعطاء النصيحة القانونية.

ENTER ADDRESSEE NAME
ENTER ADDRESSEE CARE OF
ENTER ADDRESSEE PO BOX OR STREET
ENTER ADDRESSEE CITY/STATE/ZIP

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MEDICAL VERIFICATION FOR TRANSPORTATION

INSTRUCTIONS: To be completed annually by a physician (MD or DO). Please print or type.

Medical Provider:
Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's Name		Patient's Birthdate		Medicaid ID #	
Patient Street Address		Apt/Suite	City	State	Zip Code
Preferred Contact Number					

☐ **A**	Does the patient have a chronic ongoing illness which may require multiple visits to a provider? ▶ ☐ YES ☐ NO	
☐ **B**	If yes to line A, what is the illness?	
☐ **C**	Estimated number of office or clinic visits times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify)	Will this change? ☐ YES, When _____ (Date) ☐ NO
☐ **D**	Patient's current status: ☐ Non-ambulatory ☐ Walks without restrictions ☐ Walks without assistive devices ☐ Walks with assistive device(s) ☐ Limited mobility with assistive device(s) (relies on wheeled mobility)	
☐ **E**	Does the patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ YES ☐ NO ▶	
☐ **F**	Does someone need to accompany the patient to the medical appointment? ☐ YES ☐ NO ▶	If yes, who / why?
☐ **G**	Other (Explain)	

Medical Provider Name		National Provider Identifier (NPI)		Provider's Phone No. – –
Street Address (No., Street, Bldg.)	Suite	City	State	ZIP Code
Medicaid-enrolled Provider Signature				
MDHHS Specialist Name (Print or type)				Signature Date
MDHHS Specialist Signature		I certify that the beneficiary meets requirements as listed in the Medicaid Provider Manual to receive Medicaid non-emergency medical transportation.		
Patient's or Representative's Signature				Signature Date