Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

COMMERCIAL NEMT MEDICAL NECESSITY

For services greater than 50 miles

This form must be completed and signed by a primary care or referring physician or designee (physician assistant or advanced registered nurse practitioner).
To refer a patient is to transfer their medical care from one clinician to another.
This is NOT a managed care referral.

Date

Patient name | Medicaid ID number

Diagnosis and/or procedure and reason for need to travel to the medical service

Patient is being referred to: | Physician name/provider number | Location/city

Please check one of the following options to indicate the number of trips required over a six-month period.
I am authorizing: ☐ **1-3** ☐ **4-6** ☐ **7-10**

If it is medically necessary for the beneficiary to make additional trips, a new **Commercial NEMT Medical Necessity** form must be completed.

Is an overnight stay justified for this service? ☐ Yes ☐ No
Note: Unless extenuating circumstances are present, authorization for an overnight stay will not be given if the trip is less than 200 miles from the patient's home.

Referring Provider Information

Referring provider name (printed or stamp) and provider number

Address | Phone number

I certify that the following medical services are needed by this patient and are not available closer to the patient's home.

Physician signature | **Date**

If the same provider specialty is available closer to the patient's home, explain why you are referring this patient to a provider in another city. Transportation expenses will be denied if justification is not included.

KEEP A COPY OF EACH COMPLETED FORM FOR YOUR FILE.
FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY WILL RESULT IN RECOUPMENT OF ADJUDICATED CLAIMS.

Revised 02.2013