



# Non-Emergency MEDICAL Transportation PA3 Request Form

PA3-MedicalTransport  
Form Effective: 01/18/2018  
Form Revised: 08/02/2018

**\*\*SENSITIVE BUT UNCLASSIFIED\*\***

**Submission Instructions:** Please refer to the Non-Emergency Medical Transportation Medical Coverage Determination (MCD) in the World Trade Center (WTC) Health Program Administrative Manual when completing this form. Please apply the following naming convention for labeling the PA3 Non-emergency Medical Transportation request PDF: PA3-MedicalTransport\_[respective CCE/NPN]. Send completed form to the WTC Health Program by posting it to the secure SFTP server and then sending a Personally Identifiable Information (PII)-free e-mail to [WTCMedCode@csra.com](mailto:WTCMedCode@csra.com), indicating the secure server posting of this request. Incomplete forms will be sent back for more information. **Please do not submit any other additional information or documents unless specifically requested by NIOSH.**

## Requested Code(s):

### Member Information

### CCE/NPN Requester Information

Request Date:	Member Category:	CCE/NPN Requester Name:	CCE/NPN Requester Credentials:
Member Name:	Date of Birth:	CCE/NPN Requester Fax:	CCE/NPN Requester Phone:
Member 911#:	CCE/NPN:	CCE/NPN Requester Email:	
Member Home Address:		CCE/NPN Requester Address:	

## Member's Approved WTC-Related and/or Medically Associated Condition(s)

List the member's most relevant WTC-related (RC) and/or Medically Associated Condition(s) (MAC) on the lines below. Additionally, document which condition(s) are related to this member's Medical Transport Prior Authorization Request using the check boxes to the right of the condition.

RC/MAC Code & Condition Description	Medical Transport Related	RC/MAC Code & Condition Description	Medical Transport Related
	<input type="checkbox"/>		<input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>
	<input type="checkbox"/>		<input type="checkbox"/>

## Transportation Rationale

<b>By initialing to the right of <u>each</u>* of the statements below, the CCE/NPN Clinical Director/Designee attests that there is documentation in the member's record of the member's risk of a medical emergency, the need for an ambulance or ambulance, and the following statements are applicable:</b>	
The member is assigned to a CCE- or NPN-affiliated physician or provider and the transportation is being provided to receive treatment services to manage, ameliorate, or cure a currently certified WTC-related condition or health condition medically associated to a WTC-related health condition; and	
The transportation provider is enrolled in the WTC Health Program provider network, contracted with the associated NPN provider, or is classified as a CMS provider and the transportation provider agrees to accept WTC Health Program reimbursement rates as payment in full; and	
The member has a certified WTC-related health condition or health condition medically associated with a certified WTC-related health condition. The health condition triggering the need for non-emergency medical transportation services, however, may be either the certified WTC-related health condition, the certified health condition medically associated with a certified WTC-related health condition, or another health condition in addition to the certified health condition; and	

\*Note: All of the above statements must be true in order for the member to meet the Non-Emergency Medical Transportation MCD criteria.

## Transportation Rationale (continued)

<b>By initialing to the right of <u>each</u>* of the statements below, the CCE/NPN Clinical Director/Designee attests that there is documentation in the member's record of the member's risk of a medical emergency, the need for an ambulette or ambulance, and the following statements are applicable:</b>	
The member has no other means of transportation available through public transportation, city or state public service assistance agencies, or known acquaintances; and	
The vehicle providing services to the member is traveling directly to or from one of the listed locations:	

**\*Note: All of the above statements must be true in order for the member to meet the Non-Emergency Medical Transportation MCD criteria.**

## Medical Necessity Attestation

<b>By initialing <u>at least one</u>* of the statements below, the CCE/NPN Clinical Director/Designee attests that there is documentation in the member's record of the member's risk of a medical emergency, the need for an ambulette or ambulance and the non-emergency medical transportation is determined to be medically necessary because at least one of the following criteria is established:</b>	
The member is wheelchair bound or has a disabling physical condition that requires the use of a walker or crutches and is unable to use a taxi, livery service, bus, train, or private vehicle (e.g., due to the use of a non-collapsible wheelchair or otherwise requiring a specially configured vehicle); and/or	
The member requires radiation therapy, chemotherapy, or dialysis treatments that result in a disabling physical condition, making the member unable to access transportation without personal assistance provided by non-emergency medical transportation; and/or	
The member has a severe debilitating weakness or a disabling physical condition, other than the one described above, requiring the personal assistance provided by non-emergency medical transportation; and the ordering provider certifies and provides in narrative that the member cannot be transported by taxi, livery service, bus, or private vehicle as a result; and/or	
The member is mentally disoriented as a result of medical treatment, or has a mental impairment or a disabling mental condition, and requires the personal assistance of non-emergency medical transportation; and the ordering provider certifies and provides in narrative that the member cannot be transported by a taxi, livery service, bus, or private vehicle as a result (e.g., member is disoriented to person/place/time; acute severity hallucination; delusions/inappropriate in public situations; threat/suicidal/homicidal with a plan; acute psychotic symptomatic manic episode; chemical dependency – acute withdrawal or acute intoxication); and/or	
The member has a functional orthopedic impairment precluding unassisted ambulation (bilateral or unilateral amputee, lower extremities; cast on lower extremity or half body; fracture of pelvis, hip, femur or leg; severe arthritis of locomotor joint); and/or	
The member has a neuromuscular impairment precluding unassisted ambulation (spinal injury); and/or	
The member has suffered a cerebrovascular accident with resultant hemiplegia or hemiparesis (stroke); and/or	
The member has peripheral vascular disease precluding unassisted ambulation (severe claudication; foot ulceration); and/or	
The member has severe respiratory disease (emphysema; chronic obstructive pulmonary disease; and chronic bronchitis) or cardiac disease necessitating physical assistance on stairs; and/or	
The member has some other physically disabling health condition or treatment preventing the member from being transported by a taxi, livery service, bus, or private vehicle (justify in the space below):	

**\*Note: One of the above statements must be true in order for the member to meet the Non-Emergency Medical Transportation MCD criteria.**

## Medical Transport Summary

### ORIGIN

Address of Origin:	Mode of Travel:
The address of origin should be the same as the member's home address listed above. If not, please describe in the space below why the member's home address is different than he address of origin.	

### DESTINATION 1

Round Trip

Destination 1 Address:	Appointment Date:	Appointment Time:	Destination 1 Justification: <small>(Must enter at least one)</small>
			Number of trips* within 30 days Distance in excess of 120 miles
Destination 1 Name:	Destination 1 Phone Number:		Purpose of Destination/Appointment:
If Destination 1 is a provider, is he/she a CCE/NPN-affiliated provider? (if not, justify below)			

### DESTINATION 2 (optional)

Round Trip

Destination 2 Address:	Appointment Date:	Appointment Time:	Destination 2 Justification: <small>(Must enter at least one)</small>
			Number of trips* within 30 days Distance in excess of 120 miles
Destination 2 Name:	Destination 2 Phone Number:		Purpose of Destination/Appointment:
If Destination 2 is a provider, is he/she a CCE/NPN-affiliated provider? (if not, justify below)			

### DESTINATION 3 (optional)

Round Trip

Destination 3 Address:	Appointment Date:	Appointment Time:	Destination 3 Justification: <small>(Must enter at least one)</small>
			Number of trips* within 30 days Distance in excess of 120 miles
Destination 3 Name:	Destination 3 Phone Number:		Purpose of Destination/Appointment:
If Destination 3 is a provider, is he/she a CCE/NPN-affiliated provider? (if not, justify below)			

\*Note: A Non-Emergency Medical Transportation Prior Authorization Request should only be submitted when the number of trips in a 30-day timeframe exceeds 2, and/or when the distance in mileage exceeds 120 miles.

**CCE/NPN Medical Director Concurrence:** I certify that for the non-emergency general transportation services requested and cited above, a Level 2 prior authorization has been granted by me, based upon the requirements in the Non-Emergency Medical Transportation Services Medical Coverage Determination (MCD) in the World Trade Center (WTC) Health Program Administrative Manual. This approval and all associated documentation of policy requirements and medical necessity is being maintained in the member's medical record or other NPN tracking system. These non-emergency medical transportation services are intended to facilitate access to treatment for a certified WTC-related and or medically associated health condition.

**CCE/NPN Medical Director Signature:**

**Date:**

**FOR NIOSH WTC HEALTH PROGRAM INTERNAL USE ONLY**

**Decision:**

**Decision Comments:**

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