Medical Certification of Transportation Services: Beyond 25 Miles

The patient's medical provider completes this form which will be used to verify that any trip requested over 25 miles has been confirmed as needed by the members medical provider. An established relationship or there are no closer providers to this member that can provide needed service are the reasons for submittal. This information can be called in, faxed, emailed, completed online at Medicaidco.com or mailed to Veyo.

Patient Name: ______________________ Patient Date of Birth: ____________ Patient Health First Colorado ID #: ______________

Medical Facility Information:

Medical Provider's Name: ______________________ Facility Name: ______________________

Facility Contact Person: ______________________ Phone: ______________ Fax: __________

Facility Address: ______________________ Suite: ______________ Specialty: __________

City: State: Zip:

Explain why patient cannot be seen by a provider closer to the patient's home:

Agreement and signature:

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Name of Liscensed Medical Provider: ______________________ Title: ______________

Signature of medical facility staff: ______________________ Date: ______________

Expiry Date: ______________________ Or Expiry Date Indefinite ☐

This form has changed and is no longer required to expire after 6 months.

Please call (855.264.6368) to verify the form was approved 2 business days after you submit the form.

For Colorado NEMT use only: From: __________ To: ______________ Mileage: ______________

Approve / Deny: Date: __________ Closer Facility: ______________________