Mobility Determination for Non-Emergency Medical Transportation

Universal Form for All Medicaid Plans

The following form is intended to be completed by any health care professional working with the member, including a health plan care manager or nursing facility staff. The form is intended to be valid indefinitely and can be modified at any time by submitting a new form.

Who is the member enrolled with? Check below:

- ☐ AmeriHealth Caritas New Hampshire
- ☐ BMCHP/WellSense
- ☐ NH Healthy Families
- ☐ NH Medicaid/Fee-for-Service

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
  - ☐ Carry down steps with a stretcher option
- ☐ 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 from list):
  - ☐ 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
Wheelchair weight:		☐ lbs or ☐ kgs

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Does patient use any of the following assistive devices?

☐ Walker ☐ Cane ☐ Service animal

☐ Crutches ☐ Portable oxygen

Does the patient have any of the following conditions:

☐ Alertness Issues

☐ Memory Issues

☐ Confusion

☐ Legally blind

☐ Deaf

☐ 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.

Health care professional such as RN, MD, care manager, or 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 New Hampshire	Phone: **1-833-301-2264** Fax: **1-203-375-0511**	Nteamleads@ctstransit.com
MTM Contact Center for NH Healthy Families	Phone: **1-888-597-1192** Fax: **1-877-406-0658** Attention: MTM Contact Center	CM-CenteneNH@mtm-inc.net
BMCHP/WellSense	Phone: **1-844-909-RIDE (7433)** Fax: **1-877-406-0658**	CM-WellSenseNH@mtm-inc.net
NH Department of Health and Human Services (NH DHHS)	Phone: **1-844-259-4780** Fax: **1-203-375-0511**	Nteamleads@ctstransit.com