RAPID RESPONSE
MEDICAL TRANSPORTATION

JUSTIFICATION REQUIRED FOR NON-EMERGENCY MEDICAL TRANSPORTATION

Patient's Name: _____ Date of Service:_____

Medi-Cal ID Number: _____

The transportation you requested for the above Medi-Cal beneficiary **cannot be approved nor can Rapid Response be reimbursed until we have sufficient medical information** in accordance with state regulations found in Title 22, California Code of Regulations, Section 51323, which establishes the conditions under which non-emergency medical transportation is a benefit of the Medi-Cal Program. In order to appropriately evaluate your request, all of the following items must be completed including physician signature and date of signature.

M.D., D.O., D.D.S.,

Please fill out the following completely as required by Medi-Cal:

1. **Specific Reason for the appointment:**

   _____

2. **Why is the patient unable to ambulate without assistance or be transported by private or public transportation?**

   _____

3. **Circle the mode of transportation requested:**

   Wheelchair **Gurney Van** **Ambulatory**

4. **For Multi-Trip use only:**

   The patient requires _____ per week for _____ weeks.

   Describe the treatment plan goals and expected outcomes of the prescribed visits:

   _____

MEDI-CAL PHYSICIAN CERTIFICATION STATEMENT

(Must be completed for Medi-Cal or Medicare/Medi-Cal patients)

The undersigned physician certifies that he/she is familiar with the patient's condition, has reviewed the foregoing certification and has determined that gurney van, wheelchair van or ambulatory transportation is medically necessary as specified above. A gurney van or wheelchair van service is hereby ordered.

_____ _____

PLEASE PRINT - Physician Name and Address **LICENSE #**

_____ _____

M.D., D.O., D.D.S. Signature Only **Date of Signature**

Please fax back to (916) 925-8893 or mail to: P.O. Box 348353, Sacramento, CA 95834
Questions: (916) 419-1232