



949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

Certification of Medical Necessity of Mode of Transportation

Medicaid-covered services (Fax to: 1-866-790-8808)

Instructions: Type or print clearly. All areas of this form must be completed and signed by a medical care provider* to verify the mode of transportation required for the member.

1. Member Information:

Name _____ Date of Birth _____

Address _____ Phone _____

2. Insurance Information:

'Ohana Plan ID #: _____ Medicaid ID #: _____

PCP Name: _____ Phone: _____ Fax: _____

3. Certification:

- The member does not have transportation available through self, family, friends, volunteers or others
- The member cannot ride public bus transportation

4. Mode of transportation required for Medically Necessary Medical Appointments – check the most cost effective mode of transportation that member can safely take:

- The member can ride curb to curb Handi-Van service (Handi-Van evaluation and approval required)*

*TheHandi-Van: Member can call 1-808-538-0033 for more information or to schedule an in-person interview.

- The member requires curb-to-curb taxi service, provide explanation below:
 - Medical Issue Functional Issue Cognitive Issue Mobility Issue Other
 Explain: _____

- The member requires door-to-door taxi service, provide explanation below:
 - Medical and/or Functional issue that necessitates door-to-door taxi Service:
 - Medical Issue Functional Issue Cognitive Issue Mobility Issue Other
 Explain: _____

5. Special Considerations – Check all that apply

- The member needs one personal assistant/escort throughout duration of transport (all members under age 18 need escort)
- The member needs two personal assistants/escorts throughout duration of transport
- The member uses a wheelchair for transport when outside a vehicle
- The member uses a walker when ambulating
- The member must be provided non-emergency stretcher service during transport
- The member has an elevator
- Additional passengers are problematic, no multi-loading

I, _____, the medical provider (**such as: physician, physician assistant, nurse practitioner or service coordinator*), have evaluated this member and certify that he or she is medically/functionally appropriate for the mode of transportation designated in **Section 4 above**.

Certifying Medical Provider Information:

Medical Provider Name: _____ 'Ohana
(Last, First, Middle) _____ Provider ID#: _____

Phone Number: _____ Fax Number: _____

Contact Person at Office/Phone Number: _____

Medical Provider Signature: _____ Date: _____