WISCONSIN MEDICAID

CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the program to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

The use of this form is mandatory. ForwardHealth will not accept alternate versions of this form. Completed forms that appear to be altered in ***any way*** will not be accepted. For further instructions or questions, refer to the ForwardHealth Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* or contact Provider Services at (800) 947-9627.

INSTRUCTIONS — SPECIALIZED MEDICAL VEHICLE PROVIDER

1. Give a copy of this form to the member requesting specialized medical vehicle (SMV) transportation for his or her medical care provider (evaluator) to complete if he or she does not already have a copy. ForwardHealth will not accept alternate versions of this form. Completed forms that appear to be altered in ***any way*** will not be accepted. The form is valid only if every element is completed and has the evaluating medical provider's original signature (i.e., not a stamped or photocopied signature.) ForwardHealth will not accept incomplete forms or forms without original signatures. Faxes or copies from the medical care provider are acceptable as long as they are legible and the origin and the traveling path of the form can be clearly identified. ForwardHealth will not accept illegible faxes or copies.

2. Accept the form only if the date of receipt is within 14 working days from the date the medical care provider (evaluator) signs the form. If the form indicates that the member is temporarily disabled, the certification of need is valid for the period indicated on the form in Element 4. This period must be no more than 90 days from the date the medical care provider signed the form. If the form indicates that the member is indefinitely disabled or legally blind, the certification of need is valid for three years (36 months) from the date the medical care provider (evaluator) signed the form.

3. Retain the completed original in the member's file for five years from the last date of service billed under this form. Failure to retain this form may result in recovery of payment for the SMV services provided to the member.

INSTRUCTIONS — MEDICAL CARE PROVIDER (EVALUATOR) COMPLETING FORM

Type or print clearly.

Section I

Enter the member's full name and member ID; including a middle initial is optional. The date of birth is also optional.

Section II

Determine whether or not the member has a condition that contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle. If not, ***stop*** here and refer the member to the transportation coordinator at his or her local county or tribal agency. If yes, complete Sections III and IV.

Sections III and IV

Complete Sections III and IV if the member's condition contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle. Sign and date Section IV only if the medical provider (physician, physician assistant, nurse midwife, or nurse practitioner) has evaluated this member and finds that he or she is legally blind or disabled and cannot travel safely by common carrier, such as a private vehicle or accessible mass transit. The provider's signature must be original and cannot be stamped or photocopied. Give the original form to the member and keep a copy.

Definitions

Indefinitely Disabled — As stated in DHS 107.23(1)(c)1, Wis. Admin. Code, "indefinitely disabled" means a chronic, debilitating physical impairment which includes an inability to ambulate without personal assistance or requires the use of a mechanical aid such as a wheelchair, a walker or crutches, or a mental impairment which includes an inability to reliably and safely use common carrier transportation because of organic conditions affecting cognitive abilities or psychiatric symptoms that interfere with the recipient's safety or that might result in unsafe or unpredictable behavior. These symptoms and behaviors may include the inability to remain oriented to correct embarkation and debarkation points and times and the inability to remain safely seated in a common carrier cab or coach.

Temporarily Disabled — A condition that meets the above definition but is expected to exist only for a limited time.