Letter of Medical Necessity

Instructions: *Part 1 must be completed by a health care provider, verifying the medical necessity for the recipient listed below to receive health care services greater than 25 miles distance from their home. Part 2 must be completed by the recipient, verifying if meal reimbursement will be requested while attending this appointment. To seek reimbursement, the recipient must submit this completed document and a signed Non-Emergency Medical Transportation Claim Form to the name and address listed below.*

PART 1: To be completed by the health care provider:

Recipient Name: _____Recipient PMI#:_____D.O.B._____

By signing below, I verify that I have referred the above-named health care recipient to a health care facility/provider who is located greater than twenty-five (25) miles from this recipient's home.

The above-named health care recipient is being referred to the following health care provider:

_____
Health Care Provider Name / Facility Name / Street Address / City / State / Zip

Federal Regulations mandate that recipients travel to the closest provider that will accept them as a patient. The recipient named above is requesting transportation to seek medical care at a location which is more than twenty-five (25) miles from their home. **As a current provider of health care services for this recipient, please explain *specifically* why a closer provider cannot provide medical services for the above-named recipient:**

_____
_____
_____
_____

_____Date: _____ Please Print: _____
Physician's Signature Physician's Name / Facility Name

_____
Facility Address

PART 2: To be completed by the recipient:

Please check those that apply:
☐ No reimbursement for meals will be claimed for the referral appointment described above.

If traveling greater than thirty-five (35) miles from home, I request reimbursement for the following:
☐ **Breakfast** – (Recipient must leave home prior to 6:00 a.m. for appointment described above.)
☐ **Lunch** – (Morning appointment and recipient must remain at facility for an extended time period beyond 1:00 p.m.)
☐ **Supper** – (Recipient must not have returned home before 7:00 p.m.)
Meal receipts must be attached.

Recipient should mail this completed form to:
Wright County Human Service Agency, Attn: Health Care Transportation, 1004 Commercial Drive, Buffalo, MN 55313
Faxed copies of this form will also be accepted at:
FAX: 763-682-7701 Attn: Health Care Transportation Liaison
For inquiries: Phone: 763-682-7482 or Toll Free: 1-800-362-3667, ext. 7482

Please note that faxed versions of this document are acceptable, but the accompanying Non-Emergency Medical Transportation Claim Forms must contain original signatures to be considered valid.