

WRIGHT COUNTY HUMAN SERVICES
MA Transportation - Letter of Medical Necessity

To be completed by MA Recipient (or Parent/Legal Guardian):

Patient's Full Legal Name: _____

Patient's MA (MAXIS) #: _____ Patient DOB: _____

Patient's Address: _____
Street Address City State Zip Code

Please check which of the following best describes your service request (select only one):

- I reside at the above location and have previously sought medical care within this same zip code. I am now requesting to seek medical care at a different zip code.
- I currently receive medical care at a location outside of the above zip code and plan to keep receiving service at this location outside of my home zip code.

Please answer each of the following questions:

(1) To the best of your knowledge, are there ANY medical providers of this service in your home zip code? Yes No

(2) Have you been denied service from a provider in your zip code, due to the provider not accepting MA coverage? Yes No

If yes, list the name & address of the provider who was unable to accept MA Coverage:

Please sign/date this form and **submit the form to your Primary Health Care Provider for completion.**

DATE: _____

MA Recipient's Signature (or Parent/Legal Guardian)

To be completed by Primary Health Care Provider :

To seek transportation reimbursement under the Health Care Access Program, Federal regulations **mandate that MA Recipients travel to the closest provider** that will accept them as a patient. The MA recipient named above is requesting reimbursement for transportation for medical care at a location outside of their town/city of residence zip code.

Please select the following option that best describes your relationship with this patient listed above: (select only one):

- I am a new provider for this patient, and my medical facility is located outside of their home zip code.
- I am a current Health Care Provider for this patient, and my facility is located outside of the patient's home zip code listed above. I plan to continue care to this patient and am not making a referral to another provider.
- I am a current Health Care Provider for this patient, and I am making a referral for this patient to the following Medical Treatment Facility:

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

Form continued on second page . . .

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→ **As the Primary Health Care Provider for the patient named on Page 1, please mark all that apply:**

The patient defined above requires specialized care that is not available in their home zip code. The care/ treatment required for this patient is as follows (please describe): _____

The patient currently has a physical condition that prevents their ability to safely ride in a standard-sized vehicle. The nature of their condition is as follows (please describe): _____

The nature of this medical appointment will require the patient to fast from food/drink prior to the appointment.

For safety, this patient will require someone to accompany them to this medical appointment and/or have a driver transport them to/from the appointment.

Please describe the approximate duration of time in which the treatment defined above is required for this patient:

From (Date) _____ to (Date) _____ Frequency of Treatment: _____

By signing below, I verify that I have provided accurate information regarding this patient's medical condition and ongoing service needs. I understand that under the rules of the Health Care Access Program, any referrals for service outside of the patient's home zip code cannot be reimbursed by Medical Assistance solely for purposes of maintaining an existing provider-client relationship or assurance of provider choice.

Please Print

Physician's Name _____

Facility Name: _____

Physician's Signature _____ Date _____

Facility Address: _____

Phone: _____ FAX: _____

Please mail, FAX or email a copy of this signed form to:

Wright County Human Service Agency

Attn: Health Care Transportation

1004 Commercial Drive

Buffalo MN 55313

FAX: 763-682-7701 (Attn: Health Care Transportation Liaison)

Email: Ann.Rassat@co.wright.mn.us

(Photocopied signatures of this form will be accepted.)

For additional inquiries Phone: 763-682-7482 or Toll Free: 1-800-362-3667, ext. 7482