**Medical Necessity Form**

This form is required to be completed by a medical provider for members that require a high level of transportation. This form is valid for one year from date of receipt.

**Member Information**

Full Name

|  |  |  |
| --- | --- | --- |
| ID Number | Date of Birth / / | Phone Number |

**Medical Necessity Information — Stretcher Requests Only**

 Member is continuously confined to bed.

 Member has a total body cast.

 Member has hip spicas or other casts that prevent flexion at the hip.

 Member has the following medical condition(s) making stretcher transportation necessary:

**Medical Necessity Information — Ambulance Requests Only**

 Member is continuously confined to bed.

 Member is continuously dependent on oxygen.

Member is classified as an American Heart Association Class IV patient with a disease of the heart.



 Member is receiving intravenous treatment.

 Member requires transportation after cardiac catheterization.

 Member has uncontrolled seizure disorders.

 Member is in an isolette (incubator).

 Member requires restraints as they are a possible harm to themselves or others. **(Baker Act)**

 Member is heavily sedated.

 Member is comatose.

Member has the following medical condition(s) making ambulance transportation necessary.



**Requesting Provider Attestation**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name NPI # Telephone #

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date

CERTIFICATION STATEMENT: I understand that orders for Medicaid or Medicare funded travel may result from the completion of this form. I certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form. This Certification is subject to all applicable federal, state and local laws, regulations, rules, policies and procedures.

This form can be faxed or emailed from the provider’s office to Alivi at 855-621-8962 or memberservices@alivi.com. If you have any questions, please call Alivi at the numbers below.

|  |  |
| --- | --- |
| Alivi Reservation Line – Sunshine Health LTC/COMP | 786-724-1976 |
| Alivi Reservation Line – Sunshine Health LTC/COMP (Toll-Free) | 888-863-0248 |
| Alivi Reservation Line (Toll Free) – Sunshine Health MMA (Toll-Free) | 844-352-0134 |
| Alivi Reservation Line (Toll Free) – Sunshine Health Mindful Pathways (Toll-Free) | 844-352-1485 |
| Alivi Reservation Line (Toll Free) – Sunshine Health Pathway to Shine (Toll-Free) | 844-352-0414 |
| Alivi Reservation Line (Toll Free) – Sunshine Health Power to Thrive (Toll-Free) | 888-588-9413 |