

<i>This form must be filled out completely. Write N/A when not applicable.</i>		Request Date:	
Member Name:		Date of Birth:	
Medicaid ID Number:		Associated ICD-10 Code:	
Diagnosis Description:			
Does the member need to be accompanied during travel? (<i>check one</i>) Yes No If yes, briefly explain necessity:			
Name of person accompanying member: <i>(As it appears on driver's license or other identification for commercial flights)</i>		Date of Birth:	
Member or Authorized Representative Name:		Phone #:	
Briefly describe current medical needs and condition:			
Transportation type required: (<i>check all that apply</i>)			
Personal Vehicle	Commercial Airline	Ground Ambulance	Air Ambulance (Airplane Helicopter)
Services required during transport: (<i>check all that apply</i>)			
Cardiac Monitoring	Catheter	IV Requirements	Medical Attendant Nurse
Oximeter	Respiratory Monitoring	Ventilator	Other (<i>please explain</i>)
Name of medical facility where member will receive services:			
Medical facility address:			
Medical facility contact name:			
Contact FAX number:		Contact E-Mail:	
Treating physician name:		Physician phone:	



In order to process this travel request, the following items must be provided along with the cover sheet:

Letter of medical necessity and supporting medical records from the referring provider.

Letter of acceptance from the medical facility that will be accepting the member.

Letter of acceptance from the physician who will be treating the member (*letter must include the physician contact information: phone, fax, pager, etc.*).

Treatment proposal

Confirmation that the medical facility and the physician are Utah Medicaid providers or are willing to become enrolled providers.

If the provider is not a current Utah Medicaid Provider, upon approval of the transportation request, payment rates for services will need to be negotiated with the Utah Medicaid Reimbursement Staff.

FAX this cover sheet and the required accompanying documentation to (801) 237-0750,
 Attention: Out-of-State Transportation Requests.

Inquiries about out-of-state travel requests may be made by calling (801) 538-6149.

This Section for State of Utah Medicaid Use Only

Out-of-State travel request recommendation: Approve Deny

Reason for denial: _____

Name of reviewer: _____

Signature of reviewer: _____

FAX results to (801) 237-0750, *Attention: Out-of-State Transportation Requests*

If the travel request is approved, FAX the completed cover sheet to the Office of Eligibility Policy at (801) 538-6952.

Prior to arranging for food and lodging reimbursement, the Office of Eligibility Policy will confirm that the following criteria have been met:

(All items must be checked in order to be eligible)

Member is eligible for Traditional Medicaid.

Member is NOT receiving inpatient services.

Need for food and lodging must be for a time period greater than two consecutive nights.

Service being provided must be a Medicaid covered service.

Service must be obtained at the closest facility that can possibly provide the needed service.

Inquiries about food and lodging reimbursement requests may be made by calling (801) 538-9153.