Vermont Public Transportation Association
160 Benmont Ave, Suite 11
Bennington, VT 05201
Phone: (833) 387-7200
Fax: (802) 442-0617

Physician Referral Request for Trips Under 100 Miles or Accompaniment is Medically Necessary

Please fax this form to 802-442-0617.

As the contracted Medicaid transportation provider, VPTA helps eligible people on Medicaid or Dr. Dynasaur with transportation to get to their Medicaid-billable appointments and to pick up prescriptions. This requested trip is less than 100 miles from a member's home, but it does not appear to be the closest available provider or there is a medical reason an accompaniment is necessary. Please complete both pages of this form, sign, and fax back to VPTA so that we may determine if this trip should be covered by Medicaid. This form will need to be returned to VPTA for review by _____ for VPTA to have sufficient time to make a determination.

Member Name:_____DOB: _____

Medicaid ID #:_____Phone Number:_____Member Email: _____

Appointment Date and Time: _____

Name of Primary Physician: _____

Name of Physician to whom the Member is Being Referred to: _____

Address: _____

If Applicable, Facility Name: _____

Address: _____

_____

Phone: _____

Is telehealth a viable option for this scheduled appointment? Yes ☐ No ☐

Is this the closest provider available to where the member resides? Yes ☐ No ☐
If no, please explain why on the second page.

Is overnight lodging necessary outside of a hospital? Yes ☐ No ☐
If yes, please specify the dates requested for lodging: Check In: _____ Check Out: _____

Medically, how many people should accompany the patient (including the driver)? _____
Please explain on next page.

VPTA USE ONLY - Authorized By:_____Date:_____

Approved ☐ Hardship ☐ Under 100 Miles ☐ Denied ☐

1. Is this a Clinical Trial? Yes ☐ No ☐
2. Please describe the specific service or medical care that this member needs a ride to:

_____

_____

3. If this is not the closest provider, please explain medically why the member cannot be seen closer:

_____

_____

4. Please explain in detail if there is a medical necessity for someone to accompany the member:

_____

_____

5. Does the member have a history with this specific provider? Yes ☐ No ☐
   If yes, how long? _____

6. If a history exists with this provider, please explain why the care cannot be transferred closer:

_____

_____

7. If necessary, please add any further information: _____

_____

_____

_____ _____ _____
Print name of Doctor or Doctor's Staff providing information Phone Fax

_____ _____
Signature of Doctor or Doctor's Staff providing information Date

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