Certificate of Transportation Services (CTS)

This CTS must be completed and returned by a Licensed Medical Professional.
Non-Emergency Transportation (NET) are not allowed to complete this CTS.
PLEASE USE THE MCA FORM FOR HOSPITAL DISCHARGES BY AMBULANCE

799 Roosevelt Road,
Bldg 4, Suite 200
Glen Ellyn, IL 60137
Phone: (630) 403-3210
Fax: (630) 873-1440

The following Member has requested assistance with transportation to their non emergency medical appointments. Please complete and return the following form to fax number (630) 873-1440.

Member Name: ______________________________

Member ID/ RIN: ___ ___ ___ ___ ___ ___ ___ ___ ___ Date of Birth: ______________

Category of Service Options: Please select the most economical category of service that will meet the Member's needs.

- ☐ Fixed Route Transportation — Public transportation that has an advertised route and schedule. Some examples of Fixed Route transportation include: non-commercial buses, commuter trains, subway trains, and elevated trains.
- ☐ Private Auto, Service Car, Taxi — Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode.
- ☐ Medicar — Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, or transportation by stretcher when the patient's condition does not require medical supervision, medical equipment , the administration of drugs or the administration of oxygen, etc.
- ☐ Non-Emergency Ambulance — Transportation of a patient whose medical condition requires transfer by stretcher and medical supervision. The patient's condition may also require medical equipment or the administration of drugs or oxygen, etc. during the transport.

Please check all the medical conditions that apply to the participant.

- ☐ Ambulatory – can travel safely using fixed route transportation
- ☐ Ambulatory – unable to travel by fixed route transportation
- ☐ Uses transfer wheelchair – able to step into regular car
- ☐ Needs lift: ____ unable to step into regular car ____ wheelchair bound
- ☐ Unable to be transported in sitting position
- ☐ Severe dementia – potentially combative
- ☐ Has contractures: _____ Arms _____ Legs _____ Trunk
- ☐ Ambulatory – does NOT use a walking device like walker, cane, etc.
- ☐ Ambulatory – uses walking device like walker, cane, crutches, etc
- ☐ Unable to travel alone, needs (insert number) ____ attendant (s)
- ☐ Morbidly obese – weight: _______ lbs
- ☐ Requires oxygen and is able to self administer
- ☐ Paralysis: _____ Hemi _____ Para _____ Quadra
- ☐ Requires cardiac EKG/ECG monitoring

Criteria for Non-Emergency Ambulance – Transportation of a patient whose medical condition meets the NON-EMERGENCY AMBULANCE TRANSPORTATION PATIENT CRITERIA 89 Illinois Adm. Code 140 Table A

- ☐ 1. Isolation precautions
- ☐ 2. Oxygen that is not self administered
- ☐ 3. Ventilation advanced airway management
- ☐ 4. Suctioning administration
- ☐ 5. Intravenous fluids administration
- ☐ 6. Chemical Restraints
- ☐ 7. Physical Restraints
- ☐ 8. One-on-one Supervision
- ☐ 9. Specialized Monitoring
- ☐ 10. Special Handling/Observation
- ☐ 11. Clinical Observation: Applies only to patients requiring clinical observation and treatment from one environment with 24 hour clinical observation or treatment provided by certified or licensed nursing personnel, to another environment with 24 hour clinical observation and treatment provided by certified or licensed nursing personnel. This criterion is not satisfied based solely on the type of hospital or other facility from which the patient is being transferred.

List the Member's primary and secondary diagnoses, and all other relevant medical conditions not noted above, then detail the MEDICAL NECESSITY for the requested category of service and/or need for attendants.

First Transit and HFS realize that under some circumstances a patient may require one category of service for certain medical services, like dialysis, and another category of service for other types of medical services. If special circumstances exist, please detail them below. **NOTE**: **A different category of service for certain transports cannot be requested out of convenience, it must be medically necessary and supported below.**

Certification: I certify that the information in this document supplied for the patient criteria certification constitutes true, accurate and complete information and is supported in the medical record of the patient . I understand that the information I am supplying for the patient criteria will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and / or state law, which can result in fines, civil monetary penalties or imprisonment, in addition to recoupment of funds paid and administrative sanctions authorized by law.

Printed Name AND Title of Licensed Medical Professional — Most Direct Phone Number to Validate CTS

Signature of Licensed Medical Professional — Date Signed — Authorization Expiration Date (not to exceed 6 months)