State of Illinois
Department of Healthcare and Family Services

CERTIFICATE OF TRANSPORTATION SERVICES(CTS)

THIS CTS MUST BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL AND IS REQUIRED FOR RESIDENTIAL PICKUPS.
NON-EMERGENCY TRANSPORTATION (NET) PROVIDERS ARE NOT ALLOWED TO COMPLETE THIS CTS.

Please use the PCS form for Facility Transportation and Hospital Discharges via Ambulance

The following Medicaid Customer has requested assistance with transportation to **their non-emergency** medical appointments:

Customer's Name: _____

Customer Identification Number (RIN): _____ Date of Birth: _____

Category of Service Options: Please select **the most economical category** of service that will meet the customer'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.
☐ ADA Paratransit	Curb to curb, shared ride transportation for Americans with disabilities. Paratransit vehicles include hydraulic or electric lift or ramp and wheelchair lockdowns for patients that can transport independently.
☐ 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.

REQUIRED FOR AMBULANCE:

Criteria for Non-Emergency Ambulance - Transportation of a customer whose medical condition meets the non-emergency ambulance transportation patient criteria established in 89 Illinois Adm. Code 140 Table A.

Ambulance transport for sole purpose being navigation of stairs or lifting/assisting patient does not meet medical necessity criteria.

☐ 1. Isolation Precautions for _____ Date Positive _____

☐ 2. Oxygen that is administered by a third party.

☐ 3. Ventilation Management/Suctioning Administration

☐ 4. Unable to transport in a sitting position due to: _____

(Please list medical condition prohibiting sitting position (i.e. Bilat L.E. Amputee, Poor trunk control, etc.)

☐ 5. Intravenous Fluids Administration

☐ 6. One-on-one supervision, Physical, Chemical Restraints

☐ 7. Specialized Monitoring, Clinical Observation _____

☐ 8. Paralysis: Quadra/Paraplegic without mobility device

☐ 9. Active psychiatric episode

☐ 10.Bed Confined - Any other means of transportation (i.e. taxi, w/c van, private auto) is contraindicated

NON-AMBULANCE:

Please check all medical conditions below that apply to the customer:

☐ Requires assistance navigating stairs or getting into wheelchair

☐ 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

☐ Dementia/Mental health history

☐ Has contractures: ☐ Arms ☐ Legs ☐ Trunk

☐ Ambulatory - does not use a walking device like a walker, cane, etc.

☐ Ambulatory - uses walking device like walker, cane, crutches, etc.

☐ Unable to travel alone, needs ☐ attendant(s)

☐ Obese - weight _____ lbs.

☐ Requires oxygen and is able to self-administer or uses oxygen as needed (pm)

☐ ☐ Hemi ☐ Para ☐ Quadra

Paralysis:

☐ Assistance needed to/from wheelchair

List the customer'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. **A different category of service for certain transports cannot be requested out of convenience, it must be medically necessary.**

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.

Name & Title of Licensed Medical Professional _____ Most Direct Phone # _____

Signature of Licensed Medical Professional _____ Date Signed _____

Authorization Expiration Date*_____ **Max - Up to 6 months*