cascades east transit

cet

MEDICALLY NECESSARY ATTENDANT VERIFICATION FORM

This form must be signed by client's medical provider and returned to Cascades East Transit within thirty (30) days of the medical stay in order for client or charitable facility to receive reimbursement for attendant meals/lodging.

Dear Medical Provider:

Cascades East Transit provides Non-Emergent Medical Transportation to Medicaid recipients. The client below is currently in your care. A client's attendant may receive assistance through Medicaid funds with meals and lodging to accompany the client or remain to visit an inpatient in certain situations. Please review and complete the applicable sections below

Client Full Name: _____
Client DOB:___/___/_____
Date & Time of Client Admission to Care: _____

Section A – Medical Necessity for Overnight Stay

Please check if any of the following apply to your patient:

☐ It is medically necessary for the client to travel the day before in order to attend their appointment.

☐ It is medically necessary for the client to stay overnight after their appointment and then travel home the following day.

Section B – Attendant Needed to *Travel* With Client

Please check if any of the following apply to your patient:

☐ The client is mentally or physically unable to reach his/her medical appointment without assistance

☐ The client is/would be unable to return home without assistance after treatment

☐ There is a medical need for the attendant to travel with the client **(please fill out information on medical need in Section D below)**

Section C – Attendant Need to *Visit* With Inpatient

☐ There is a medical need for the attendant to visit with an inpatient client **(please fill out information on medical need in Section D below)**

Section D – Medical Necessity of Attendant

It is medically necessary for an attendant to (complete as applicable):

☐ **Travel** with Client because (please state medical reason):

_____
_____
_____
_____

☐ **Visit** with Inpatient Client because (please state medical reason):

_____
_____
_____
_____

✎ Attendant should visit with the client (anticipated frequency or schedule of medically necessary visits):

_____
_____

✎ Client, at this point is anticipated to remain an inpatient at this facility until: _____(indicate "Unknown" if no approximation can be made)

_____ Date:_____
Attending Physician's Signature
Printed Name: _____

_____ _____
_____ Attending Physician's Phone No.
_____
_____
Attending Physician's Address
(include Facility Name)