

### Physician Referral Form

Please fax this form to 802-879-5919.

The Department of Vermont Health Access (DVHA) helps people on Medicaid or Dr. Dynasaur with transportation to get to their Medicaid-billable appointments or pick up prescriptions. If the requested trip is **over 100 miles** from a member's home, please complete and sign this form in order for us to determine if this trip should be covered by Medicaid.

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Member Email: \_\_\_\_\_

Appointment Date: \_\_\_\_\_ and Time: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_

Name of Physician to whom  
Member is Being Referred to: \_\_\_\_\_

If Applicable, Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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 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.

**DVHA USE ONLY** - Authorized By: \_\_\_\_\_ Date: \_\_\_\_\_

Approved  Hardship  Under 100 Miles  Denied

Lodging  Dates \_\_\_\_\_ Meals  If meals, # of people \_\_\_\_\_ Parking/Tolls

CPT Code: \_\_\_\_\_

HCPCS Code: \_\_\_\_\_

1. Is this a Clinical Trial? Yes  No

2. Please describe the specific medical service this member needs a ride to:

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

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

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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:

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7. If this is an out-of-state/out-of-network request, please answer the following:

Does this member have a primary insurance other than VT Medicaid? Yes  No   
If no, a clinical prior authorization may be needed before this transportation request can be considered. For questions pertaining to this process please call 800-925-1706.

8. If necessary, please add any further information: \_\_\_\_\_

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\_\_\_\_\_  
Print name of Doctor or Doctor's Staff providing information

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Signature of Doctor or Doctor's Staff providing information

\_\_\_\_\_  
Date