Vermont Public Transportation Association

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 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. Please describe the specific service or medical care that this member needs a ride to:

____

____

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

____

____

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

____

____

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

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

____

____

6. 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