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 <u>over 60 miles</u> 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: _____

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: _____

<u>Medically</u>, how many people should accompany the patient (including the driver)? _____
Please explain on next page.

DVHA USE ONLY - Authorized By: _____Date:_____

Approved ☐   Hardship ☐   Under 60 Miles ☐   Denied ☐

Lodging ☐ Dates _____ Meals ☐ If meals, # of people_____ Parking/Tolls ☐

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

    Does this member have a primary insurance?   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.

7. If necessary, please add any further information: _____

_____

_____ _____ _____

Print name of Doctor or Doctor's Staff providing information   Phone   Fax

_____ _____

Signature of Doctor or Doctor's Staff providing information   Date