215 Pleasant Street | Bennington, VT 05201
(802) 447-0477 | Fax (802) 214-2262
www.greenmountainexpress.com

# ***Physician Referral Request for Trips <u>Under 100 Miles</u> or Accompaniment***

**Please fax this form to 802-214-2262.**

As the contracted Medicaid transportation provider, GMCN helps eligible people on Medicaid or Dr. Dynasaur with transportation to get to their Medicaid-billable appointments and to pick up prescriptions. If the requested trip **is <u>less than 100 miles</u>** 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 then please complete both pages of this form, sign, and fax back to GMCN so that we may determine if this trip should be covered by Medicaid. This form will need to be returned to GMCN for review by ______________________ For GMCN 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 the 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: ________

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

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**GMCN USE ONLY -** Authorized By:________________________________Date:__________________

Approved ☐ Hardship ☐ Under 100 Miles ☐ Denied ☐

1. Is this a Clinical Trial? Yes ☐ No ☐
2. Please describe the specific service or medical care that this member needs a ride to:

______________________________________________________________________

______________________________________________________________________

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

______________________________________________________________________

______________________________________________________________________

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

______________________________________________________________________

______________________________________________________________________

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:

______________________________________________________________________

______________________________________________________________________

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

*rev 9.1.22*