Ceeccil Quality Care Transportation LLC
2720 E Yampa St, Suite 2A, Colorado Springs, CO 80909
Monday – Saturday | 04:00 AM – 10:00 PM
Phone: (720) 669-0696 | Fax: (720) 615-8666
Email: cs@ceeccil.com | Website: www.ceeccil.com

Level of Service - Medical Verification Form

Dear Medical Professional,

We have received a request for non-emergency medical transportation (NEMT) for one of your patients. Please fill out this medical verification form completely and provide any supporting information, as needed.

Fax it back to us: 720-615-8666. This form will be used to determine the patient's most appropriate mode of NEMT transportation based on his/her functional abilities and limitations.

Patient Information:

FIRST NAME: _____ LAST NAME: _____ DATE OF BIRTH: _____

MEDICAID ID#: _____ PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: ___

Member Home life: (Lives alone/family, Group home, Nursing or Rehab facility) _____

Health Information:

Diagnosis that supports transportation limitation, must provide ICD-10 code: _____

_____.

Special Assistance? Blind, Visually Impaired, Deaf, Use of service dogs and animals, None, Other,

describe: _____

Mobility Aids or Devices? Wheelchair, Electric wheelchair, XL Wheelchair (is wider than 20"

across and patient exceeds 350lbs), Mobility scooters, walkers, None, Other, describe: _____

If XL Wheelchair, Weight of Patient: _____ HGT: _____ **Patient Transfer (wheelchair), describe:** ____

Does the patient require an escort to travel with? _____

Additional Comments: _____

Medical Professional Information:

Medical Professional Printed Full Name: _____ Phone: _____

Name/Credential of Professional: _____ NPI: _____

Medical Facility Name: _____

Medical Facility Address: _____

By signing, the medical professional certifies and attests that each statement is accurate and true to the best of their knowledge.

Signature: _____