VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

Phone (802) 879-5900

IN-STATE, OUT-OF-AREA/OUT-OF-STATE MEDICAID TRANSPORTATION PHYSICIAN REFERRAL FORM

The Department of Vermont Health Access provides travel assistance to eligible Medicaid recipients to access necessary medical services. Please provide the following information to help us provide that assistance. Thank you.

Physician's Office: Please mail or fax completed form to:
Medicaid Transportation, Department of Vermont Health Access,
312 Hurricane Lane, Suite 201, Williston, VT 05495 / Fax: (802) 879-5919.

Client Name _____

Medicaid Number_____ DOB_____

Appointment Date and Time _____

Name of Primary Physician _____

Name of physician to whom
patient is being referred _____

Address _____

_____

Phone # _____

Is overnight lodging necessary? Yes____ No____

Should a person accompany the client? Yes ____ No____
Reason: Minor ____
Medical condition requiring assistance ____ (please explain on page 2)

Local Transportation Broker Name: _____

Address: _____

_____

Phone #: _____

Medical Reason for someone to accompany: _____

_____

Please describe the specific service or care requested: _____

_____

Please check "yes" or "no" to all of the following questions. If necessary, use an additional sheet of paper:

YES	NO	
☐	☐	Is this service obtainable in Vermont?
☐	☐	Have efforts been made to find a closer provider?
☐	☐	Does the requested physician possess special expertise?
☐	☐	Is it medically necessary for this physician to treat this patient?
☐	☐	Does the patient have a history with this specific provider?
☐	☐	Can another physician take over this case if a history does exist?
☐	☐	Is a Prior Authorization required from the DVHA Clinical Unit?
☐	☐	Is this Prior Authorization in place?

If necessary, please add any further information: _____

_____

_____

_____

_____

_____ _____

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

_____ _____

Signature of Doctor or Doctor's Staff providing information Date
(if phone contact, broker staff filling out this form)