



**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 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: \_\_\_\_\_

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. Is this a Clinical Trial? Yes  No

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

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

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

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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:

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7. 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