VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
Phone: (802) 879-5900
Fax: (802) 879-5919

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 **over 100 miles** 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: _____ Fax: _____

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 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.

DVHA USE ONLY - Authorized By: _____Date:_____

Approved ☐ Hardship ☐ Under 100 Miles ☐ Denied ☐

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

CPT Code:_____ HCPCS Code: _____

1. Is this a Clinical Trial? Yes ☐ No ☐

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

_____

_____

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

_____

_____

4. Please explain in detail if there is 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 this is an out-of-state/out-of-network request, please answer the following:

   Does this member have a primary insurance other than VT Medicaid? 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.

8. 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