Distance Verification Form

Member's referring or rendering health care provider must complete this form.

Member's Name: _____ D.O.B.: _____

Member's ForwardHealth ID: _____ Appt. Date: _____

Referring or Rendering Health Care Provider: _____

Phone #: _____

You have referred and/or will be treating the above-named member at

_____

(Name of health care provider, facility, and address of facility).

The member named above is requesting transportation to seek health care at a distant Wisconsin Medicaid/BadgerCare Plus health care provider.

Please list reason why this member cannot be seen by a health care provider nearer to their home:

_____

_____

Please provide specific medical services and doctor types/specialties:

_____

_____

Is this a one-time authorization? ☐ Ongoing treatment? ☐

If ongoing treatment, please specify end date of approval _____

_____ _____

Referring/Rendering Health Care Provider's Signature — Date

_____ _____

Referring/Rendering Health Care Provider's Address — National Provider ID (Required)

Please fax this completed form at least 2 business days prior to the appointment. Veyo cannot arrange transportation to the requested location until we review and process this document.

Fax: 888-506-7708 Attn: Clinical Coordinator