Level of Need Assessment Form
Ambulance/Stretcher

Facility Fax:

Dear Health Care Provider,

Our office has received a request for non-emergency medical transportation for a Wisconsin Medicaid or BadgerCare Plus member. This form will be used to determine the patient's most appropriate mode of transportation based on his or her functional abilities and limitations. **Please fill out this Ambulance/Stretcher Level of Need Assessment form completely and provide any supporting information as needed.**

Patient Info	First Name:	Last Name:	Date of Birth:	Gender: ☐ M ☐ F
	ForwardHealth ID #:		Room #:	
	Address:	City:	State:	Zip:
Diagnosis Info	Diagnosis that supports transportation limitations (MUST PROVIDE):		Diagnosis is: ☐ Permanent ☐ Temporary Through (date): ______	
	Does this patient have any of the following impairments? ☐ Muscular/Motor ☐ Respiratory ☐ Cardiac Function ☐ Cognitive/Psychological ☐ Other If you checked any box above, please explain:			
Transport Needs	Does this patient use any of the following assistive devices? ☐ Crutches ☐ Walker ☐ Cane ☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Scooter			
	Is this patient able to sit in a wheel chair? ☐ Yes ☐ No If no, please specify reason(s):			
	Does this patient require monitoring by a certified Emergency Medical Technician (EMT) or paramedic during transport? ☐ Yes ☐ No			
	Does this patient require use of oxygen during transport? ☐ Yes ☐ No			
	Does this patient require transportation provider to administer medication? ☐ Yes ☐ No			
	Does this patient require transportation provider to use needles or make cuts to skin? ☐ Yes ☐ No			
	Does this patient need to be lifted or carried up/down stairs in order to exit the home or provider's building? ☐ Yes ☐ No			
	Is this patient able to transfer into vehicle without assistance ☐ Yes ☐ No			
	Does this patient require life-sustaining equipment during transport? ☐ No ☐ Yes If yes, please specify:			
	Does this patient need to be transported in a reclining position? ☐ No ☐ Yes, for medical reasons ☐ Yes, due to a psychiatric condition If yes, please explain:			
	Does this patient require a personal attendant? ☐ No ☐ Yes, for medical reasons ☐ Yes, passenger is developmentally disabled ☐ Yes, passenger is cognitively disabled			

CERTIFICATION STATEMENT: I (or the entity) understand(s) that orders for Medicaid or BadgerCare Plus funded travel may result from the completion of this form. I (or the entity) certify (ies) that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form. This Certification is subject to all applicable federal, state and local laws, regulations, rules, policies and procedures.

Health Care Professional Info	Print Name and Credentials:		NPI #:
	Address:		Phone #:
	Signature:		Date:
Form completed by:		Title:	Phone #:

Questions? Please call Veyo at 866-907-1493.

Fax this completed form to: 888-506-7708, ATTN: Ambulance/Stretcher Authorization Specialist