

MASSHEALTH PRESCRIPTION FOR TRANSPORTATION FORM

Please indicate the type of request: New form Renewal Increase in visits Alternate pick-up address

Please print or type all information.

1. MassHealth Member Information

Last name		First name		Date of birth	
Member ID					Tel. no.
HOME ADDRESS (The MassHealth member will be transported to and from this address, unless an alternate pick-up address is listed.)					
Street address		Apt. no.	City/Town		State Zip
ALTERNATE PICK-UP ADDRESS					
Street address		Apt. no.	City/Town		State Zip
MAILING ADDRESS (If different from Home address.)					
Street address		Apt. no.	City/Town		State Zip

2. MassHealth Provider Information (Section to be completed by the provider requesting transportation.)

Name of treating provider/facility		Tel. no.		Ext	
Street address		Suite no.	City/Town		State Zip
MassHealth Provider ID/Service location				NPI	

3. Name and Location of Treating Provider/Facility (Indicate where the MassHealth member will be seen.) Check if same as provider listed in Section 2.

Name of treating provider/facility		Tel. no.		Ext	
Street address		City/Town		State Zip	
MassHealth Provider ID/Service location				NPI	
Is the treating facility within the member's locality (city or town of residence, or adjacent city or town)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If No, please justify:					

4. Medical Treatment Type

Please list the MassHealth-covered service(s) that the member is receiving at this location.

5. Duration and Frequency of Treatment

How long will the MassHealth member require these services?	<input type="checkbox"/> week(s)	<input type="checkbox"/> month(s)
How frequently will the MassHealth member be seen for this service?	<input type="checkbox"/> visit(s) per week	<input type="checkbox"/> visit(s) per month

6. Why Transportation Services Are Required

Is there a medical reason why the member (or guardian if accompanying a minor) is unable to use public transportation? Yes No

If Yes, please cite specific medical reason:

7. Other Information

Is a wheelchair van needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is an escort accompanying the member for assistance with ambulation or to accompany a minor?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Specify other transportation needs:

8. Provider Signature

Signature: _____ Date: _____

Please check appropriate title: MD DDS RNP RNC Other Please list title: _____

Do not write below this line - MassHealth use only

APPROVED. Authorization expires on: _____ Tracking no.: _____

DENIED. Reason: _____

MassHealth Authorized Signature: _____ Date: _____

Instructions for Completing the Prescription for Transportation Form

Section 1 – Enter the member’s name, date of birth, MassHealth member ID, telephone number, and home address, including apartment number, if applicable.

In certain circumstances MassHealth may authorize a member to be picked up at an address other than his/her home address. If the member is to be picked up at an alternate address, enter the alternate address information below the home address information. If there is a mailing address that is different from the home address, enter that below the alternate pick-up address.

Section 2 – Enter the provider’s name, telephone number, address, MassHealth provider ID and location code, and the NPI.

The provider requesting transportation should be a physician, physician’s assistant, nurse midwife, dentist, nurse practitioner, psychologist, or managed care representative, and an active MassHealth provider.

Section 3 – If the provider is also the treating provider, place a check mark in the box labeled “Check if same as provider listed in Section 2.” If the treating provider is different from the provider filling out Section 2, enter that provider’s name, telephone number, address, and, if it is known, their MassHealth provider ID and location code, and the NPI.

If the treatment destination is outside of the member’s locality (city or town of residence, or immediately adjacent communities), indicate why the medical care is unavailable to the member within the member’s locality.

Section 4 – Indicate the specific medical care that will be provided.

Section 5 – Indicate how many weeks or months the member will require transportation, and how frequently the member will be going per week or per month for the service. MassHealth will not authorize more than six months of transportation for an acute illness, or one year of transportation for a chronic illness. For a single visit, enter “1” week, and “1” visit per week.

Section 6 – Indicate if there is a medical reason that the member (or guardian, in accompanying the member) is unable to use public transportation. Provide the specific physical or mental disability that prevents the member from using public transportation.

Section 7 – Indicate if a wheelchair van or an escort is necessary.

Wheelchair van transportation may be provided for non-emergency medical services for members who use a wheelchair or whose severe mobility impairments prevent them from traveling in a vehicle other than a wheelchair van.

Section 8 – The signature of the physician, physician’s assistant, nurse midwife, dentist, nurse practitioner, psychologist, managed care representative, or dental third-party administrator is required to process the PT-1 form. The provider’s signature indicates that all information contained on the form is accurate to the best of his/her knowledge.

For more detailed information about the MassHealth transportation benefit, consult the MassHealth transportation regulations at 130 CMR 407.000. If you have any questions about completing this form, please call the MassHealth Transportation Authorization Unit at 1-800-841-2900.