



Verification form for transportation services more than 25 miles

The member's medical provider must complete this form to verify the medical necessity of trips that exceed 25 miles, one way.

Patient Information	First Name	Last Name
	Date of Birth	Member Medicaid ID #
Medical Facility Information	Treatment Location Name	
	Treatment Location Address	
	Medical Provider's Name & Title	
	Contact Name & Title	
	Contact Phone	Medicaid Provider ID #
Term of Verification	Date(s) Verification is Valid For	Date(s) of Trip

Reason patient cannot be seen by a medical provider who is less than 25 miles away:

Medical Provider Attestation

I understand that if I have given false information or intentionally failed to disclose information, I may be subject to prosecution, criminal, civil, or both. I certify under penalty of perjury, that I have obtained the information on the form from the patient or their representative, and the information provided is accurate to the best of my knowledge.

Printed Name of Facility Staff _____ ID _____

Facility Staff Signature _____ Date _____

This form is valid for 30 days per member for regular trips to treatment locations.

This trip must meet the requirements in 10CCR 2505-10 Section 8.014, Non-Emergent Medical Transportation.

For questions or if you need assistance please visit hcpf.colorado.gov/provider-help