

# Level of Need / Medically Appropriate Mode Form



This form must be completed by a healthcare provider indicating the most medically appropriate mode(s) of transportation for the Priority Health member.

MEMBER INFORMATION	
First Name	Last Name
Member ID Number	Date of Birth (MM/DD/YYYY)

<b>Please check all that apply to member:</b>	<input type="checkbox"/> Requires oxygen that is self-administered	<input type="checkbox"/> Pediatric, Age: _____	<input type="checkbox"/> Has Multi-Loading Restriction
	<input type="checkbox"/> Traveling with ADA service animal	<input type="checkbox"/> Bariatric, Weight: _____ Height: _____	If checked, please specify multi-loading restrictions: _____
	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Other, please list: _____

Which transportation option is best suited for this member?	Diagnosis / Medical Necessity
<input type="checkbox"/> Public Transportation (select if member has no multi-loading restrictions and can walk 0.25 miles at a time)	
<input type="checkbox"/> Ambulatory (select if member cannot take public transit and can get into/out of a regular sedan style vehicle)	
<input type="checkbox"/> Wheelchair Vehicle (select if member requires a wheelchair accessible vehicle)	
<input type="checkbox"/> Stretcher Vehicle (select if member requires a stretcher vehicle)	

How long will the member require this level of service?	Supporting Information
_____Weeks      _____Months	Please include any additional supporting information that would help Veyo understand the member's medical circumstance / needs.

PROVIDER INFORMATION		
Provider First Name	Provider Last Name	Facility Phone

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.

**Please submit completed forms**  
by email to [miptsupport@veyo.com](mailto:miptsupport@veyo.com)  
or by fax to 1-855-667-2557

X

Provider's Signature

Date