



Ohio Department of Medicaid
**CERTIFICATION OF NECESSITY
 FOR TRANSPORTATION
 BY WHEELCHAIR VAN**

Patient Sticker
 Here

Individual Information

- | | |
|--|---|
| 1. Name <i>(Enter the full name of the individual transported.)</i> | 2. Ohio Medicaid Billing Number — 12 Digits |
| 3. Address <i>(Enter the individual's home address. This information may be used to confirm the identity of the individual.)</i> | |

Transportation Provider Information

- | | |
|--|---|
| 4. Provider Name <i>(Enter the business name of the transportation provider.)</i>
MERCY HEALTH REGIONAL TRANSPORT, LLC | |
| 5. Ohio Medicaid Provider Number — 7 Digits | 6. National Provider Identifier (NPI), If Applicable — 10 Digits
1720851504 |

Certification

- | | |
|---|---|
| 7. Criteria

<i>By signing this document, the practitioner certifies that two statements are true:</i>
a. This individual must be accompanied by a mobility-related assistive device from the point of pick-up to the point of drop-off.
b. Transport of this individual by standard passenger vehicle or common carrier is precluded or contraindicated. | 8. Period Beginning Date <i>(Enter the first date of the certification period.)</i> |
| | 9. Length <i>(Mark one box to indicate the length of time for which the individual is certified for transport. For certification on a temporary basis, specify the number of calendar days, up to 90. If no time period is indicated, then the certification is valid for the Period Beginning Date only.)</i>

☐ Not more than day(s)
☐ One year |

Additional Information Relevant to Certification

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|---|
| 10. Comments or Explanations, If Necessary or Appropriate |
|---|

Certifying Practitioner Information

- | | |
|---|--|
| 11. Name of Practitioner <i>(Enter the full name of the certifying practitioner.)</i> | |
| 12. Ohio Medicaid Provider Number, If Applicable — 7 Digits | 13. National Provider Identifier (NPI) — 10 Digits |

Signature Information

- | | |
|---|----------------------------|
| 14. Date of Signature | 15. Name of Person Signing |
| 16. Signature and Professional Designation <i>(Persons who, with proper authority or approval, sign on behalf of the certifying practitioner must include the practitioner's name as well as their own signature and designation or job title.)</i> | |

False certification constitutes Medicaid fraud.

This form confirms the certification of one individual for transport by one service provider; certification is not transferrable between individuals or service providers. A photocopy, an electronic copy, or a facsimile transmittal of the completed, signed, and dated certification form is as valid as the original for documentation purposes. Completion of this form is required in accordance with Chapter 5160-15 of the Ohio Administrative Code.