

Closest Provider Certification



This form must be completed by a healthcare provider to verify any trip outside of the member’s local community—over 10 miles in urban areas and 20 miles in rural areas—is medically needed. For more information on rural areas, please visit: <http://www.ruralhealthct.org/towns.htm>

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

HEALTHCARE FACILITY INFORMATION NOTE: Must Be a Participating Medicaid Provider			
Healthcare Provider's Name	Facility Name		
Type of Facility <input type="checkbox"/> Behavior Health <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Clinic <input type="checkbox"/> FQHC <input type="checkbox"/> Other _____	Phone Number		
Facility Address	City	State	Zip Code

MEDICAL REASON
<p>Please specify the medical reason for the member needing to travel beyond 10 miles (urban) / 20 miles (rural) for care:</p> <p><input type="checkbox"/> Services are not available closer to the member’s home</p> <p><input type="checkbox"/> Closest provider available for critical care/advanced treatment/medical services</p> <p><input type="checkbox"/> Closest provider available for urgent treatment</p> <p><input type="checkbox"/> Engaged in additional level of care at facility</p> <p><input type="checkbox"/> Current ongoing course of treatment requiring continuity of care</p> <p><input type="checkbox"/> Other, please explain: _____</p>

SUPPORTING INFORMATION
<p>Please include any additional supporting information that would help Veyo understand the member’s medical circumstance / needs.</p>

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.

X

 Provider Signature

 Date

Please submit completed forms by email, mail, or fax:

Email: ctcc@veyo.com

Fax: 860-920-7743

Mail: Veyo
 Attn: Clinical Coordinator
 100 Pearl St., 14th Floor
 Hartford, CT 06103