

Companion Request Form



This form is to be completed by a healthcare provider to communicate to Veyo when a HUSKY Health member needs to travel with an attendant or escort due to a **physical, mental or intellectual medical condition** that prevents the member from traveling alone safely.

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

COMPANION MEDICAL NECESSITY
<input type="checkbox"/> Member is medically able to travel without a companion
<input type="checkbox"/> Member is medically unable to travel without a companion (if selected, please complete questions 1-2 below)
1. Please describe the member's medical condition/s that requires the assistance of a companion? _____ _____
2. Does this member need a companion for all medical appointments, or just for specific visits (such as dialysis)? _____ _____

HEALTHCARE PROVIDER INFORMATION	
First Name	Last Name
Facility Name	Phone Number

- Please make sure all information is accurate and complete before signing
- Companion Referral Forms expire twelve (12) months from signature date

By signing this form, I acknowledge that any statements made above regarding the member/companion medical necessity are true and accurate, under the penalty of **Medicaid Fraud**.

X _____
Provider's 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