





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

MEMBER INFORMATION						
First Name				Last Name		
Medicaid ID Number				Date of Birth (MM/DD/YYYY)		
Please check all that apply to member:		☐ Requires oxygen that is self-administered ☐ Pediatric, Age: ☐ Has		as Multi-Loading Restriction		
		If ch		checked, please specify multi-loading restrictions:		
		☐ Traveling with ADA service anim	mai 🗆 Bariatric	, weight: Height: =		
		□ Wheelchair	☐ Durable Medical Equipment ☐ Oth		ther, please list:	
Which transportation option is best suited for this member? Diagnosis / Medical Nece					Diagnosis / Medical Necessity	
	Public Transportatio	n select if member has no multi-l	oading restrictions and ca	n walk 0.75 miles at a time		
	Livery / IDP	select if member cannot take public transit and can get into/out of a regular sedan style vehicle				
	Wheelchair Vehicle	select if member requires a wheelchair accessible vehicle				
	BLS	select if member requires Basic Life Support (BLS) during transport				
	ALS	select if member requires Adva	nced Life Support (ALS) d	uring transport		
Have been will the mamber require this level of comics? Comparing Information						
			Supporting Information			
Weeks		Months	Please include any additional sup	porting information that would help Veyo understa	nd 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						

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 penalt 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's Signature
Date

Please submit completed forms by email at ctcc@veyo.com, or fax to 860-920-7743, or mail to Veyo, Attn: Clinical Coordinator, 100 Pearl St., 14th Floor, Hartford, CT 06103