



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

Individual Information

ALL FIELDS ARE REQUIRED

1. Name <i>(Enter the full name of the individual transported.)</i>	2. Ohio Medicaid Billing Number — <i>12 Digits</i>
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> AmeriKare LLC	
5. Ohio Medicaid Provider Number — <i>7 Digits</i> N/A	6. National Provider Identifier (NPI), If Applicable — <i>10 Digits</i> 1699070201

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 <u>one</u> 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> <input type="checkbox"/> Not more than 60 day(s)
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Additional Information Relevant to Certification

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 — <i>7 Digits</i>	13. National Provider Identifier (NPI) — <i>10 Digits</i>

Signature Information

14. Date of Signature	15. Name of Person Signing – PLEASE PRINT LEGIBLY
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.