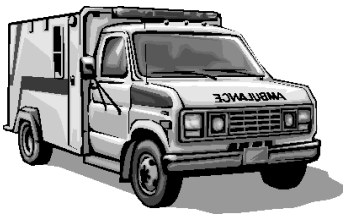

Ohio Department of Medicaid

CERTIFICATION OF NECESSITY FOR NON-EMERGENCY TRANSPORTATION BY GROUND AMBULANCE

Individual Information ***ALL FIELDS ARE REQUIRED***

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

Transportation Provider Information

4. Provider Name *(Enter the business name of the transportation provider.)* **AmeriKare LLC**	
5. Ohio Medicaid Provider Number — *7 Digits* **N/A**	6. National Provider Identifier (NPI) — *10 Digits* **1699070201**

Certification

7. Criteria *(Mark each reason why transport is being certified as necessary for this individual.)* During transport, this individual requires: ☐ medical treatment or continuous supervision by an EMT. ☐ the administration or regulation of oxygen by another person. ☐ supervised protective restraint.	8. Period Beginning Date *(Enter the first date of the certification period.)* 9. Length *(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.)* ☐ Not more than 60 day(s)

Additional Information Relevant to Certification

10. Comments or Explanations, If Necessary or Appropriate –

Certifying Practitioner Information

11. Name of Practitioner *(Enter the full name of the certifying practitioner.)*	
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 – **PLEASE PRINT LEGIBLY**
16. Signature and Professional Designation *(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.)*	

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.