COLORADO
Department of Health Care Policy & Financing

Health First COLORADO
Colorado's Medicaid Program

Verification form for transportation services more than 25 miles

The member's medical provider must complete this form to verify the medical necessity of trip requests that exceed 25 miles, one way. This form can be faxed or emailed to Transit To Care.

Patient Information	Fist Name	Last Name	DOB	Medicaid ID
Medical Facility Information	Facility Name			
	Facility Address			
	Medical Provider's Name and Title			
	Contact Name and Title			
	Contact Phone	Contact Email		

Reason patient cannot be seen by a closer medical provider who is less than 25 miles away:

Medical Provider Attestation	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.	
	Printed Name of Facility Staff	Title
	Signature of Facility Staff	Date

Term of Verification	Date(s) Verification is Valid For	Date(s) of Trip

This form cannot be completed after the trip has been rendered. This trip must meet the requirements in 10CCR 2505-10 Section 8.014, Non-Emergent Medical Transportation. For questions or if you need assistance please visit hcpf.colorado.gov/provider-help