

**WISCONSIN MEDICAID  
 CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION**

**Instructions:** Type or print clearly. All areas of this form must be completed and signed by a medical care provider (evaluator) to verify the need for specialized medical vehicle (SMV) transportation. Only a physician, physician assistant, nurse midwife, or nurse practitioner may be an evaluator and sign this form. Refer to the Certification of Need for Specialized Medical Vehicle Transportation Completion Instructions, F-1197A, for information on completing this form.

<b>SECTION I — MEMBER INFORMATION</b>		
1. Name — Member (Last, First, Middle Initial)	2. Member Identification Number	3. Member's Date of Birth (MM/DD/YY) (Optional)

<b>SECTION II — ELIGIBILITY FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION</b>
<p>4. Does the member have a physical / mental impairment that contraindicates safe travel by common carrier such as accessible mass transit, taxi, or private vehicle?</p> <p>If "no," then <b>STOP</b> here. Do <b>not</b> complete or sign this form. Instead, refer the member to the Medicaid transportation coordinator at his or her local county or tribal agency.</p> <p>If "yes," then complete Sections III and IV of this form.</p>

<b>SECTION III — DIAGNOSIS INFORMATION AND VERIFICATION OF MEDICAL CONDITION</b>
<p>5. I have evaluated this member and certify that he or she is one of the following. (Refer to the completion instructions of this form for definitions of indefinitely and temporarily disabled.) (Check one.)</p> <p><input type="checkbox"/> Indefinitely disabled. This form is valid for three years (36 months) from the date signed by the medical care provider.</p> <p><input type="checkbox"/> Legally blind. This form is valid for three years (36 months) from the date signed by the medical care provider.</p> <p><input type="checkbox"/> Temporarily disabled. This form is valid for no more than 90 days from the date signed by the medical care provider. (This certification of need may be renewed after 90 days, if necessary.)</p> <p>If less than 90 days, state expected duration of disability: _____ days</p>

<p>6. Does the member require the use of a wheelchair or scooter?</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
------------------------------------------------------------------------------------------------------------------------------------------

<p>7. The evaluating medical provider is required to explain in the space provided why the member's physical / mental condition requires transportation in an SMV and why the member cannot access mass transit, taxi, or a private vehicle. Include the diagnosis, if possible.</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<b>SECTION IV — MEDICAL CARE PROVIDER (EVALUATOR) INFORMATION</b>		
<p>I, the medical provider (physician, physician assistant, nurse midwife, or nurse practitioner), have evaluated this member and certify that he or she has a condition that contraindicates safe travel by common carrier, such as private vehicles or mass-transit services, and requires the use of an SMV for transportation to receive medical services.</p>		
8. SIGNATURE — Evaluator	9. Date Signed — Evaluator	
10. Name — Evaluator (Print)	11. Position Title — Evaluator	
12. National Provider Identifier	13. Taxonomy Number (Optional)	14. Practice Location ZIP+4 Code (Optional)