Enrollee Name: ____ Enrollee Date of Birth: _____________ Enrollee Client ID Number: _________________

6. Enter all relevant medical, mental health or physical conditions and/or limitations that impact the required mode of transportation for this enrollee in the box below. Please include the level of assistance the enrollee needs with ambulation. (Example – enrollee requires 2-person assistance or enrollee requires 1-person assistance). If you answered Yes to question 3 or any part of question 5, it is important you provide as much detail as possible as to why you believe the enrollee's medical condition aligns with the requested mode of transportation. Insufficient details may cause the Form 2015 to be rejected and may lengthen the time it takes to get the enrollee approved for the higher mode of transportation.

Please indicate below the anticipated length of time this enrollee will require a higher mode of transportation:

☐ Temporarily until __/__/____ ☐ Long Term (9-12 months) until __/__/____ ☐ Permanent (subject to periodic review)

CERTIFICATION STATEMENT: I (or the entity making the request) understand that orders for Medicaid [illegible] may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department including 18 NYCRR 504.8(a)(2), which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) certify that the statements made herein are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.

__Medical Provider Information__

Medical Provider's Name: ____________________________________ NPI #: ______________ Date of Request: ____________

Clinic/Facility/Office Name: ______________________________ Telephone #: ________________________ Fax #: ________________

Clinic/Facility/Office Address: ______________________________ City: ____________________ State: ________ Zip: __________

Name of person completing this form (Print): ____________________________________ Title: ______________________

Name of Medical Provider attesting that all the information on this form is true (Print): ______________________________

Signature of Medical Provider: ____ Date: __________________