



**FIDELIS CARE**  
NEW YORK

**AMBULETTE & LIVERY  
NON-EMERGENCY TRANSPORTATION SERVICES  
FAX TO:  
TRANSPORTATION UNIT  
FAX#: (716) 564-6250  
TELE#: 1-888-FIDELIS (1-888-343-3547)**

**MEMBER SECTION**

Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex \_\_\_\_\_  
Address: \_\_\_\_\_ Apt.# \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone # ( ) \_\_\_\_\_  
Fidelis I.D. # \_\_\_\_\_ Social Security # \_\_\_\_\_  
Medicaid # \_\_\_\_\_

.....  
**PRIMARY CARE PROVIDER OR SPECIALIST SECTION**

PCP Name: \_\_\_\_\_  
Site Location: \_\_\_\_\_  
Telephone # ( ) \_\_\_\_\_  
License # \_\_\_\_\_

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**MEDICAL INFORMATION**

List Diagnoses (PRINT) 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_  
Why do these diagnoses justify transportation other than Public Transportation?

\_\_\_\_\_  
Does the patient use a wheelchair, scooter or portable oxygen? Yes \_\_\_\_\_ No \_\_\_\_\_  
Is the member departure/destination point within his/her county? Yes \_\_\_\_\_ No \_\_\_\_\_  
If not, justify travel outside the County

\_\_\_\_\_  
Please indicate mode of transportation requested: (Please note that clinical information must justify mode of transportation requested). ( ) Ambulette ( ) Livery

Provider Name \_\_\_\_\_ Date of Appointment \_\_\_\_\_

Provider Name \_\_\_\_\_ Date of Appointment \_\_\_\_\_

Provider Name \_\_\_\_\_ Date of Appointment \_\_\_\_\_

\*Authorizations, if approved, will only be provided for the provider above dates and times. Maximum three (3) dates per Request Form. An updated form will be required for any appointments in addition to the above or when the member's condition results in a change of transportation mode.



Member Name: \_\_\_\_\_  
ID # \_\_\_\_\_

**Acute and Chronic Conditions Only\*\*:** Authorization is from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_.

**\*\* (Note: An authorization may cover a one way trip; or up to a three month period for patients with acute conditions or chronic conditions.)**

**Certification Statement:**

I (or the entity) understand that orders for Fidelis Medicaid-funded travel may result from the completion of this form. I (or the entity) understand and agree to be subject to and bound by all Fidelis and/or the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State and any other publications of the Department, including Regulation 504.8(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) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.

Fidelis does not intend to limit a Member's freedom to choose any Fidelis Medicaid provider in the State of New York. Fidelis Member's are allowed to receive care and services from any practitioner willing to provide care. However, Fidelis is not required to pay the transportation expenses of a member to accommodate one's choice when the same medical service is available closer to one's residence. By ordering transportation services for Fidelis Medicaid Members traveling outside the county or neighboring county of where the Member resides, I (or the entity) certify that the Fidelis Medicaid Member requires specialized care not available within the specified area.

This request may be reviewed by a member of the Quality Healthcare Management staff. Please be advised that an incomplete request form will delay the approval process. All sections must be filled out completely to proceed to the review and approval process. **Once received allow 3 business days for authorization.**

**Dear Provider: To avoid delays in the provision of transportation services please ensure that the box below is checked, signed and dated.**

**I have personally reviewed the certification statement and the medical information contained in this form and it is true, correct and complete to the best of my knowledge.**

**Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

\_\_\_\_\_  
**(Please print provider's full name)**

\_\_\_\_\_  
**(Date)**

\_\_\_\_\_  
**(Provider Signature)**

\_\_\_\_\_  
**(Date)**