VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Department of Vermont Health Access
208 State Drive, NOB 1 South
Waterbury, VT 05671-1010
Phone: (802) 879-5900
Fax: (802) 879-5919

Physician Referral Form

Please fax this form to 802-879-5919.

The Department of Vermont Health Access (DVHA) helps people on Medicaid or Dr. Dynasaur with transportation to get to their Medicaid-billable appointments or pick up prescriptions. If the requested trip is over 100 miles from a member's home, please complete and sign this form in order for us to determine if this trip should be covered by Medicaid.

Member Name: ________________________ DOB: ____________ Medicaid ID #: _____________

Phone Number: ________________ Member Email: ____

Appointment Date: _______________ and Time: ________________

Name of Primary Physician: ____

Name of Physician to whom
Member is Being Referred to: ____

If Applicable, Facility Name: ____

Address: ____

____

Phone: ______________________________

Is this the closest provider available to where the member resides? Yes ☐ No ☐
If no, please explain why on second page.

Is overnight lodging necessary outside of a hospital? Yes ☐ No ☐ If yes, please specify the dates requested for lodging: Check In: ___________________ Check Out: _____________________

Medically, how many people should accompany the patient (including the driver)? ______________
Please explain on next page.

DVHA USE ONLY - Authorized By: ____________________________Date:_________________

Approved ☐ Hardship ☐ Under 100 Miles ☐ Denied ☐

Lodging ☐ Dates __________________ Meals ☐ If meals, # of people______ Parking/Tolls ☐

CPT Code: ______________________________ HCPCS Code: ____________________________

1. Please describe the specific service or medical care that this member needs a ride to:

2. If this is not the closest provider, please explain medically why the member cannot be seen closer:

3. Please explain in detail if there is medical necessity for someone to accompany the member:

4. Does the member have a history with this specific provider? Yes ☐ No ☐
   If yes, how long? __________________________________

5. If a history exists with this provider, please explain why the care cannot be transferred closer:

6. If this is an out-of-state/out-of-network request, please answer the following:

   Does this member have a primary insurance? Yes ☐ No ☐
   If no, a clinical prior authorization may be needed before this transportation request can be considered. For questions pertaining to this process please call 800-925-1706.

7. If necessary, please add any further information:

____ ______________ ______________
Print name of Doctor or Doctor's Staff providing information Phone Fax

____ _______________
Signature of Doctor or Doctor's Staff providing information Date